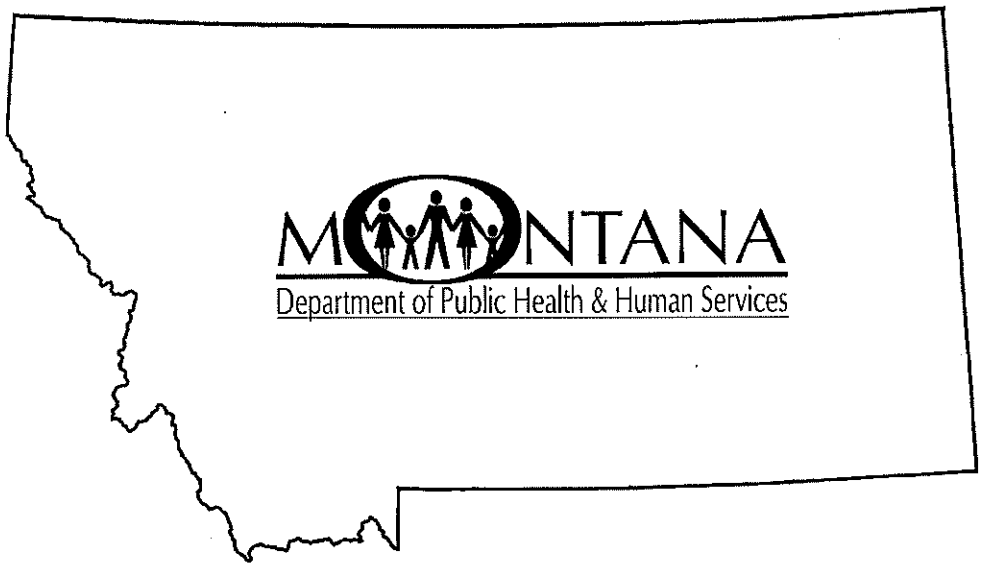
THE MONTANA MEDICAID PROGRAM

State Fiscal Years 2003/2004 Report for the 2005 Legislature



A report by the Montana Department of Public Health and Human Services

Contents:

The Montana Medicaid Program is authorized under 53-6-101, Montana Codes Annotated, and Article XII, Section 3 of the Montana Constitution. The Department of Public Health and Human Services (DPHHS) administers the program.

Program Mission:

To assure that necessary medical care is available to all eligible Montanans within available funding resources.

Basic Objectives:

•To promote the maintenance of good health by Medicaid eligible persons

•To assure that Medicaid eligible persons have access to necessary medical care

•To assure that the quality of care meets acceptable standards

•To promote the appropriate use of services by Medicaid eligible persons

•To assure that services are provided in the most cost effective manner

•To assure that only medically necessary care is provided

•To assure that the Medicaid program is operated within legislative appropriation

•To assure that prompt and accurate payments are made to providers

•To assure that accurate Medicaid program and financial information is available for management on a timely basis

•To assure that confidentiality and privacy of client information is maintained at all times

•To promote the appropriate utilization of preventive services

MEDICAID PROGRAM MANAGEMENT:

John Chappuis **DPHHS Deputy Director** **Medicaid Director** **444-4084**	
Chuck Hunter **Administrator** **Health Resources** **444-4458**	Joe Mathews **Administrator** **Disability Services** **444-2590**
Joyce DeCunzo **Administrator** **Addictive & Mental Disorders** **444-3969**	Shirley K. Brown **Administrator** **Child & Family Services** **444-5900**
Kelly Williams **Administrator** **Senior & Long Term Care** **444-4047**	Mary Dalton **Administrator** **Quality Assurance Division** **444-2037**
Hank Hudson **Administrator** **Human & Community Services** **444-5901**	Jane Smilie, Acting **Administrator** **Public Health & Safety** **444-9020**

PROGRAM MANAGEMENT RELATIONSHIP TO MEDICAID:

JOHN CHAPPUIS, DEPUTY DIRECTOR, STATE MEDICAID DIRECTOR
- oversight of all Medicaid programs for State of Montana

CHUCK HUNTER, ADMINISTRATOR, HEALTH RESOURCES DIVISION
- hospital services (inpatient and outpatient)
- physician and mid-level practitioner services
- managed care (primary care case manager, PASSPORT Program) and Nurse First
- mental health services for children
- dental services
- (non-physician) licensed provider services (e.g. optometrist, therapists, audiologist, etc)
- Indian Health Service facilities
- targeted case management services for children with special health care needs
- ambulance and transportation services
- pharmacy services
- school-based services
- durable medical equipment

JOE MATHEWS, ADMINISTRATOR, DISABILITY SERVICES DIVISION
- waivers for persons with Developmental disability
- targeted case management services for persons ages 16+ with Developmental disability
- Montana Development Center (facility for persons with developmental disability)

JOYCE DECUNZO, ADMINISTRATOR, ADDICTIVE & MENTAL DISORDERS DIVISION
- mental health services for adults
- chemical dependency treatment
- inpatient psychiatric hospital services
- inpatient psychiatric nursing home services

SHIRLEY K. BROWN, ADMINISTRATOR, CHIILD & FAMILY SERVICES DIVISION
- targeted case management services for children at risk of abuse and neglect

KELLY WILLIAMS, ADMINISTRATOR, SENIOR & LONG TERM CARE DIVISION
- long term care services in the community
- home & community based waiver for adults and physically disabled individuals
- nursing facility services, including Montana Veteran Home

MARY DALTON, ADMINISTRATOR, QUALITY ASSURANCE DIVISION
- facility licensing
- fraud and program compliance
- surveillance utilization & review
- third party liability

HANK HUDSON, ADMINISTRATOR, HUMAN & COMMUNITY SERVICES DIVISION
- Medicaid eligibility

JANE SMILIE, ACTING ADMINISTRATOR, PUBLIC HEALTH & SAFETY DIVISION
- targeted case management services for high risk pregnant women
- breast and cervical cancer screening program for low-income women

MEDICAID PROGRAM OVERVIEW:

The Montana Medicaid program is a joint federal-state program that pays for a broad range of medically necessary health care and long-term care services for certain low income populations. The State administers the program in a partnership with the federal Centers for Medicare and Medicaid Services (CMS). The State is responsible for determining eligibility for low-income populations including pregnant women, children, individuals with disabilities and the elderly. The Medicaid benefits package is broad and flexible and may range from preventive services to long-term care. The Montana Medicaid program has flexibility with CMS to: 1) design our own benefits package subject to certain minimum requirements and 2) determine provider reimbursement rates based on approved methodologies.

Medicaid services are funded by a combination of federal and state (and in some situations, local) funds. In Montana, the matching rate is approximately 70% federal and 30% state funds. Simply stated, if DPHHS receives 30 cents in general funds, the 30 cents becomes a Medicaid dollar. Some Medicaid services receive an enhanced federal match rate such as services provided in Indian Health Service Facilities at 100%; for family planning services at 90%; and services through the breast and cervical cancer program at 80%. In addition, administrative costs of the State are matched at 50% and data systems are matched at 75%.

Medicaid benefits are a defining element of an individual's eligibility. Federal law requires individuals eligible for Medicaid are entitled to the following services unless waived under Section 1115 of the Social Security Act. These are referred to as mandatory services and include:

- Physician & Nurse Practitioner
- Nurse Midwife
- Medical & Surgical Service of a Dentist
- Laboratory and X-ray
- Inpatient Hospital (excluding inpatient services in institutions for mental disease)
- Outpatient Hospital
- Federally Qualified Health Centers
- Rural Health Clinics
- Family Planning
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Nursing Facility
- Home Health
- Durable Medical Equipment

States may elect to cover other optional services. Montana has chosen to cover a number of cost-effective optional services including, but not limited to, the following:

- Outpatient Drugs
- Dental and Denturist Services
- Comprehensive Mental Health Services
- Ambulance
- Physical & Occupational Therapies and Speech Language Pathology
- Transportation & Per Diem
- Home & Community Based Services
- Eyeglasses & Optometry
- Personal Assistance Services
- Targeted Case Management
- Podiatry

Indian Health Service (IHS) Facility: The Montana Medicaid Program provides reimbursement for covered medical services to Medicaid-eligible Native Americans who receive those services through an Indian Health Service (IHS) facility or other approved tribal provider. By law, the Medicaid program acts as the "pass through" agency for these services that are funded with 100% federal funds.

Medicaid reimburses outpatient IHS services on an all-inclusive, encounter basis and pays for inpatient services using a per diem payment. The fiscal 2004 reimbursement rates are:

Inpatient Hospital – $1,526
Inpatient Physician – $142
Medication refills – $150
Vaccinations – $9.50
Outpatient Services - $216
(Includes clinic, vision, dental & hearing)

State Fiscal Year	Expenditures
2002 (7-1-01---6-30-02)	$17,151,315
2003 (7-1-02---6-30-03)	$21,223,578
2004 (7-1-03---6-30-04)**	$22,307,048

**SFY 2004 figures reflect claims submitted by August 2004. Providers may submit claims 365 days from the date of service and not all claims may have been submitted/paid.

The Department contracts with the IHS to provide services at the following eleven locations in Montana: Browning, Crow Agency, Harlem, Lodge Grass, Poplar, Hays, Heart Butte, Pryor, Lame Deer, St. Ignatius, and Wolf Point. The facilities at Browning, Crow Agency, and Harlem provide both inpatient and outpatient services. All other facilities provide only outpatient services. The Department also contracts separately for services at the Rocky Boy reservation since they are a self-governing tribal entity. The Indian Health Board of Billings, the Helena Indian Alliance, and the Native American Center of Great Falls operate and are paid as FQHC's.

ELIGIBILITY

Although State participation in Medicaid is optional, any State that has Medicaid programs must provide coverage to certain groups or "categories" of people – referred to as categorically eligible. These mandatory groups are described below.

Mandatory Populations

Families with Dependent Children:
Families whose income and resources are below the Family Related Medicaid limits may receive Medicaid. The eligibility for Medicaid is determined separately from TANF.

Pregnant Women
Low-income pregnant women are eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL), and their resources do not exceed $3,000 (chart for 133% of FPL is in the children eligibility section).

- Premature babies and medically involved babies are often extremely costly in terms of direct medical expenses. The average estimated cost to Medicaid for a high-risk infant is $53,000.

- Pregnancy is expensive: $12,100 is the average cost to Medicaid for prenatal care, delivery and newborn pediatric care – compared to $300 per person per year for family planning services.

- In Montana during state fiscal year 2003 (July 1, 2002 through June 30, 2003), over 45 percent of childbirths were paid for through Medicaid.

Children
Medicaid is the largest provider of health coverage for children in the State of Montana. During 2003 the average number of children enrolled each month was 43,000. Children are eligible for Medicaid if their family's countable resources do not exceed $3,000 and if the family meets other financial and non-financial criteria. Eligibility differs by age group.

- Children in Specialized Adoption or Foster Care
  Any child eligible for an adoption subsidy through the Department, Child and Family Services Division, is automatically eligible for Medicaid. Any child placed by the Department's Child and Family Services Division into licensed foster care is eligible for Medicaid.

- Infants and Children through Age 5
  These children are provided with full coverage under the Medicaid program if family income is less than 133% of the Federal Poverty Level (FPL).

- Children Ages 6 through 18

Children ages 6 through 18 are covered if family income is not greater than 100% FPL. Federal OBRA 89 required states to implement minimum coverage for children ages 6 through 18 at 100% of the FPL.

2003 Federal Poverty Level Gross Monthly Income		
Family Size	100% FPL	133% FPL
1	$748	$995
2	$1,010	$1,343
3	$1,272	$1,691
4	$1,533	$2,039
5	$1,795	$2,387
6	$2,057	$2,735
7	$2,318	$3,083
Over 7 add for each child	$262	$348

Early and Periodic Screening, Diagnostic and Treatment Benefit

Early and periodic screening, diagnostic and treatment services (EPSDT) are a required service under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population. However, if the EPSDT benefit is elected for the medically needy population, the EPSDT benefit must be made available to all Medicaid eligible individuals under age 21.

A Comprehensive Child Health Program --The EPSDT program consists of two, mutually supportive, operational components: 1) assuring the availability and accessibility of required health care resources and 2) helping Medicaid recipients and their parents or guardians effectively use them.

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to systematically:

- Seek out eligible individuals and inform them of the benefits of prevention and the health services and assistance available,
- Help them and their families use health resources, including their own talents and knowledge effectively and efficiently,
- Assess the child's health needs through initial and periodic examinations and evaluation, and
- Assure that health problems found are diagnosed and treated early before they become more complex and their treatment more costly.

Administration. States have the flexibility within the Federal statute and regulations to design an EPSDT program that meets the health needs of recipients within its jurisdiction (as long as the state stays within the federally established framework, standards and requirements).

Under the EPSDT benefit States must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. States must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with established periodicity schedules for these services. Additionally, the Act requires that any service which States are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in the State Medicaid plan.

The statute provides an exception to comparability for EPSDT services. Under this exception, the amount, duration and scope of the services provided under the EPSDT program are not required to be provided to other program eligible individuals or outside of the EPSDT benefit. Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

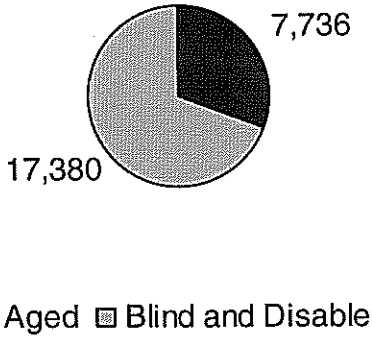
People Who Are Aged, Blind, or Disabled and Receiving Supplemental Security Income (SSI)

Low income aged and disabled persons make up a large group within the Medicaid program. Many aged, blind, and disabled clients live alone and struggle to maintain independence despite health conditions requiring regular medical attention. Medicaid is critical to maintaining their access to medical care and thereby supports a higher level of independence, often reducing the need for more costly medical and support services.

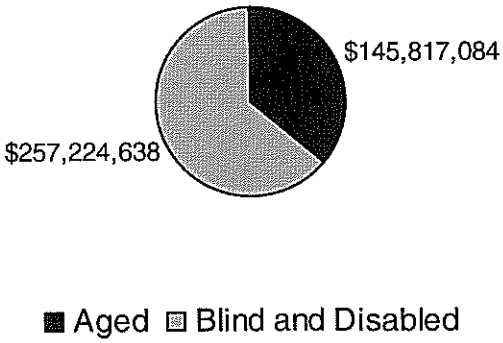
Persons who are aged, blind, or disabled and whose income and resources are below federal Supplemental Security Income (SSI) limits may receive both SSI cash benefits and Medicaid, or they may receive Medicaid only. The Department's Disability Determination Bureau determines disability status for the SSI program. Aged, blind, or disabled persons with income above the SSI standards may be eligible for Medicaid under the medically needy program.

2003		
Family Size	Resource Limit	Monthly SSI Income Limit
1	$2,000	$564
2	$3,000	$846

2003 AVG Monthly Enrollment



Fiscal Year 2003 Expenditures



Optional Populations:

Extended Medicaid:
Under certain conditions, families are eligible for up to 12 months of extended Medicaid coverage after their eligibility for Section 1931 Medicaid coverage ends due to new or increased earned income. The first six months of this coverage, called Extended Medicaid, is not dependent on income. To remain eligible in the final six months, the family income must be less than or equal to 185% of the federal poverty level. The family must meet all other eligibility criteria for the entire 12 months.

Family Size	Monthly Income limit-Transitional SFY 2003
1	$1,384
2	$1,869
3	$2,353
4	$2,837
5	$3,321
6	$3,805
7	$4,289
8	$4,773
9	$5,257

Breast or Cervical Cancer
The Montana Legislature passed legislation creating the Montana Breast and Cervical Cancer Treatment group effective July 1, 2001. Low income uninsured women who are screened through the National Breast and Cervical Cancer Early Detection Program and are diagnosed with breast and/or cervical cancer or pre-cancer receive Basic Medicaid coverage.

To qualify, the woman must be age 64 or younger, have countable income less than or equal to 200% of the Federal Poverty Level, not be eligible for any other category of Medicaid, and do not have creditable coverage. There is no resource limit for this program.

Medically Needy
Medically Needy is a federally matched Medicaid program for persons whose resources are less than $2,000 for an individual (or $3000 for a couple/family) and whose monthly income is more than the relevant categorically needy or income limit. The family-related medically needy program is not tied to SSI limit. This is a federal optional program that the Montana Legislature has chosen to implement.

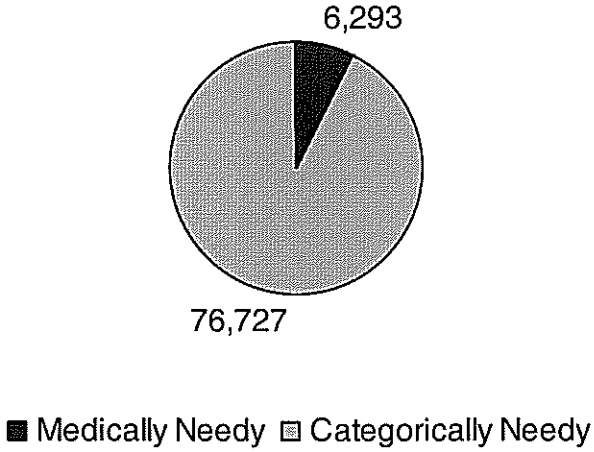
Individuals with income above the Categorically Needy program limits are considered Medically Needy and responsible each month for their medical bills until they have incurred enough medical expenses equal to the difference between their countable income and the medically

needy income level. Individuals may be Medicaid eligible the first of the month by paying this same amount directly to DPHHS. The individual's "spenddown" amount – the monthly amount the individual must incur before Medicaid coverage applies – is based on income. Medicaid eligibility begins at the end of the spenddown period and continues through the end of the month.

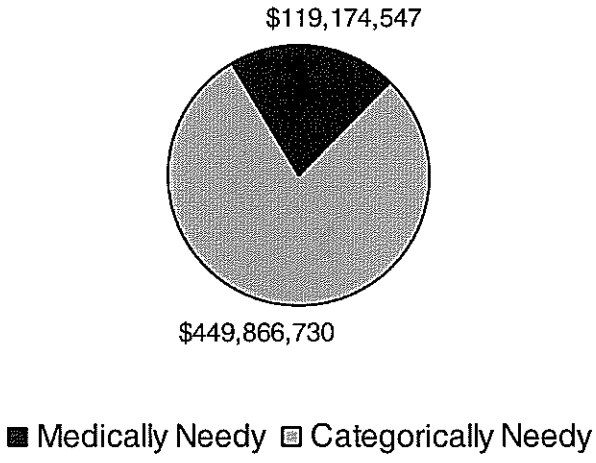
State Fiscal Year 2003 Limits for Medically Needy

Family Size	Resource Limit	Monthly Income Limit
1	$2,000/$3,000**	$525
2	$3,000	$525
3	$3,000	$658
4	$3,000	$792
5	$3,000	$925
6	$3,000	$1,058
7	$3,000	$1,192
8	$3,000	$1,317
9	$3,000	$1,383
10	$3,000	$1,450
**$2,000 for aged, blind, or disabled individuals, $3,000 for family-related programs and for aged, blind, or disabled couples.		

2003 AVG Monthly Enrollment



Fiscal Year 2003 Expenditures



STATE FISCAL YEAR 2003 DATA

Summary of Medicaid Enrolled persons for state fiscal year 2003 (July 1, 2002 – June 30, 2003)

	Average Monthly Enrollment						
Beneficiary Characteristic	**All**	**Aged**	**Blind & Disabled**	**Adults**	**Children**	**% of Medicaid Total**	**% of Montana Population**
Total	83,020	7,736	17,380	14,890	43,014	100%	
Age							
5 and Younger	19,776	-	506	-	19,270	24%	6%
6 to 19	25,749	-	2,005	-	23,744	31%	19%
20 to 64	27,983	25	14,025	13,933	-	34%	61%
Over 65	9,512	7,711	844	957	-	11%	13%
Gender							
Male	35,505	1,937	8,272	3,848	21,448	43%	50%
Female	47,515	5,799	9,108	11,042	21,566	57%	50%
Race							
White	60,078	6,997	14,421	9,974	28,686	72%	91%
Native American	19,746	615	2,525	4,411	12,195	24%	6%
Other	3,196	124	434	505	2,133	4%	3%
Assistance Status							
Medically Needy	6,293	4,204	1,832	6	251	8%	
Categorically Needy	76,727	3,532	15,548	14,884	42,763	92%	
Medicare Status							
Part A and B	16,230	7,573	7,242	1,415	-	20%	
Part A only	98	19	60	19	-	0%	
Part B only	272	109	144	19	-	0%	
None	66,420	35	9,934	13,437	43,014	80%	

As indicated above Medicaid provides services to a disproportionately high percentage of women, children and Native Americans.

Enrollment and Expenditures by County

County	Population as of July 1, 2003	AVG Medicaid Enrollment	% on Medicaid	Rank by % on Medicaid	Expenditures	AVG Expenditure per Recipient	Rank by AVG Expenditure per Recipient
Beaverhead County	8,919	691	8%	31	$ 4,569,826	$ 6,613	37
Big Horn County	12,894	2,580	20%	3	$ 11,803,217	$ 4,575	53
Blaine County	6,729	1,158	17%	4	$ 5,874,211	$ 5,073	49
Broadwater County	4,430	393	9%	22	$ 2,737,715	$ 6,966	34
Carbon County	9,770	518	5%	42	$ 4,058,256	$ 7,834	23
Carter County	1,333	61	5%	48	$ 1,052,048	$ 17,247	2
Cascade County	79,561	7,312	9%	21	$ 49,374,541	$ 6,753	36
Chouteau County	5,576	272	5%	46	$ 3,322,368	$ 12,215	9
Custer County	11,369	1,160	10%	17	$ 11,291,987	$ 9,734	15
Daniels County	1,940	98	5%	44	$ 1,093,786	$ 11,161	11
Dawson County	8,776	567	6%	35	$ 8,255,625	$ 14,560	5
Deer Lodge County	8,953	1,123	13%	11	$ 8,680,778	$ 7,730	24
Fallon County	2,752	165	6%	40	$ 2,045,929	$ 12,400	7
Fergus County	11,695	907	8%	30	$ 9,081,797	$ 10,013	13
Flathead County	79,485	6,340	8%	27	$ 38,938,605	$ 6,142	40
Gallatin County	73,243	2,735	4%	54	$ 16,729,406	$ 6,117	41
Garfield County	1,233	62	5%	45	$ 511,521	$ 8,250	19
Glacier County	13,250	3,550	27%	2	$ 15,800,954	$ 4,451	54
Golden Valley County	1,047	100	10%	20	$ 353,111	$ 3,531	56
Granite County	2,894	149	5%	43	$ 1,213,221	$ 8,142	21
Hill County	16,350	2,389	15%	7	$ 13,180,917	$ 5,517	46
Jefferson County	10,499	458	4%	50	$ 15,378,198	$ 33,577	1
Judith Basin County	2,192	161	7%	32	$ 1,167,998	$ 7,255	29
Lake County	27,197	3,509	13%	10	$ 20,637,012	$ 5,881	43
Lewis and Clark County	57,137	4,766	8%	24	$ 35,611,001	$ 7,472	27
Liberty County	2,055	61	3%	55	$ 763,462	$ 12,516	6
Lincoln County	18,835	2,496	13%	9	$ 13,342,744	$ 5,346	47
McCone County	1,818	274	15%	6	$ 2,100,186	$ 7,665	25
Madison County	6,967	69	1%	56	$ 1,011,510	$ 14,660	4
Meagher County	1,967	137	7%	34	$ 1,287,065	$ 9,395	16
Mineral County	3,884	597	15%	5	$ 3,109,152	$ 5,208	48
Missoula County	98,616	7,890	8%	26	$ 55,471,452	$ 7,031	33
Musselshell County	4,464	484	11%	16	$ 2,719,061	$ 5,618	45
Park County	15,840	987	6%	38	$ 7,067,995	$ 7,161	31
Petroleum County	491	19	4%	52	$ 78,106	$ 4,111	55
Phillips County	4,271	430	10%	18	$ 3,248,627	$ 7,555	26
Pondera County	6,166	755	12%	12	$ 4,306,635	$ 5,704	44
Powder River County	1,834	81	4%	49	$ 920,424	$ 11,363	10
Powell County	7,006	449	6%	36	$ 3,620,228	$ 8,063	22
Prairie County	1,154	93	8%	25	$ 758,875	$ 8,160	20
Ravalli County	38,662	2,712	7%	33	$ 17,608,580	$ 6,493	39

The Montana Medicaid Program

State Fiscal Years 2003/2004 Report for the 2005 Legislature

County	Population as of July 1, 2003	AVG Medicaid Enrollment	% on Medicaid	Rank by % on Medicaid	Expenditures	AVG Expenditure per Recipient	Rank by AVG Expenditure per Recipient
Richland County	9,155	730	8%	28	$ 6,283,591	$ 8,608	18
Roosevelt County	10,451	3,033	29%	1	$ 14,699,707	$ 4,847	51
Rosebud County	9,303	1,314	14%	8	$ 6,555,416	$ 4,989	50
Sanders County	10,455	1,050	10%	19	$ 6,276,810	$ 5,978	42
Sheridan County	3,668	232	6%	37	$ 2,874,421	$ 12,390	8
Silver Bow County	33,208	4,019	12%	13	$ 28,433,515	$ 7,075	32
Stillwater County	8,459	360	4%	51	$ 2,579,894	$ 7,166	30
Sweet Grass County	3,604	167	5%	47	$ 1,729,924	$ 10,359	12
Teton County	6,369	348	5%	41	$ 3,481,370	$ 10,004	14
Toole County	5,337	322	6%	39	$ 2,783,388	$ 8,644	17
Treasure County	735	28	4%	53	$ 135,527	$ 4,840	52
Valley County	7,349	835	11%	14	$ 6,184,990	$ 7,407	28
Wheatland County	2,106	237	11%	15	$ 1,557,290	$ 6,571	38
Wibaux County	977	76	8%	29	$ 1,247,617	$ 16,416	3
Yellowstone County	133,191	11,270	8%	23	$ 78,468,065	$ 6,963	35
Other/Institutions		241			$ 5,571,623	$ 23,119	
Montana	**917,621**	**83,020**	**9%**		**$569,041,277**	**$ 6,854**	

**SOURCE: Population Estimates Program, Population Division, U.S. Census Bureau, Washington, DC 20233

The eligibles and spending data excludes CHIP.

MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES

The Addictive and Mental Disorders Division (AMDD) provides Medicaid funded mental health services to 16,500 adults and 8,900 youth in SFY 2003. This represents an increase of approximately 21% over the SFY 2001 recipient caseload.

In July 2004, administration of children's mental health services was transferred to the Health Resources Division and addiction services to children were maintained in AMDD. Information presented here represents both child and adult mental health services in SFY 2003 that were provided by AMDD.

The mental health program provides a full array of outpatient and inpatient services to adults and youth suffering from mental illnesses through a fee-for-service system with Montana community providers. The community providers deliver services such as therapies, adult foster and group care, day treatment, rehabilitation and support, care coordination and case management services. The program provides inpatient and outpatient hospital services and out-of-home care services including residential treatment, therapeutic foster and group care.

To deliver the variety of services, the program utilizes the services of licensed professional counselors, physicians, hospitals, psychologists, psychiatrists, social workers, mental health centers, mid level practitioners, and out-of-home providers for group care and residential treatment.

AMDD's chemical dependency program provides a full array of outpatient and inpatient services to youth, and outpatient services to adults through a fee-for-service system with Montana community providers. Community providers consist of 2 inpatient free standing residential treatment providers and 17 outpatient service providers. The community providers deliver services such as assessment, individual and group therapies, family and family group therapies, case management (liaison services) for youth and adults. Community providers deliver free-standing residential day treatment and free-standing inpatient 24 hour – 7 day a week service for youth.

To deliver the variety of services, the program utilizes the services of state-approved substance dependency and abuse treatment programs under contract with the Division's Chemical Dependency Bureau. The primary professional involved in the service delivery within these providers is a licensed addiction counselor. Inpatient and day treatment service requires prior written approval from the Chemical Dependency Bureau as well as continue care reviews.

WAIVERS

General Description: WAIVERS
State Medicaid programs may waive certain requirements, such as statewideness, freedom of choice, or comparability.

- States may *pay for medical care in the home* for persons who would otherwise be financially eligible (due to the income and resources of a spouse or parent) only in an institutional setting. This is important for families facing institutionalizing a child or family member in order to receive assistance with the medical costs.
- States may *target services to particular groups*, such as elderly individuals, technology-dependent children, individuals with traumatic brain injuries, or persons with mental retardation or developmental disabilities. This means, however, that if you receive services in one State, you may not automatically receive them in another State.

Section 1115 waivers of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration project(s) which, in the judgment of the Secretary,(are) likely to assist in promoting the objectives of (the Medicaid statute).

1115 waivers allow flexibility, which is sufficiently broad to allow States to test substantially new ideas of policy merit. States commit to a policy experiment that will be evaluated. Section 1115 should demonstrate something that has not been demonstrated on a widespread basis, the specific research / demonstration finding will be drawn from the projects results.

Section 1915(b) waivers of the Social Security Act provides "the Secretary may . . . waive such requirements of section 1902(other than sections 1902(a) (13)(E) and 1902(a)(10)(A) insofar as it requires provision of care and services described in section 1905(a)(2)(C))."

Section 1915 (b) waivers allow States to waive statewideness, comparability of services, and freedom of choice. 1915(b) waivers are limited in that they apply to existing Medicaid eligible beneficiaries, authority under this waiver cannot be used for eligibility expansions. There are four 1915(b) Freedom of Choice Waivers:
(b)(1) mandates Medicaid Enrollment into managed care
(b)(2) utilize a "central broker"
(b)(3) uses cost savings to provide additional services
(b)(4) limits number of providers for services

Section 1915(c) waivers are referred to as the Medicaid home and community-based services waiver program and are alternatives to providing long-term care in institutional settings. Section 1915(c) of the Act authorizes the Secretary of Health and Human Services to waive certain Medicaid statutory requirements to enable you to cover a broad array of home and community-based services as an alternative to institutionalization.

Waivers for Persons with Developmental Disability (DD)

•The Developmentally Disabled Waiver (0208.90)----------1915(c):
This waiver was initiated in 1981 (one of the first waivers in the country) to provide community based services to persons receiving services in a small program which had been decertified as an ICF-MR. This waiver has grown in size and scope during the past 20+ years. For the period 7/1/02-6/30/03, Medicaid reimbursed $45,681,551 for 1,533 persons with DD in this waiver. Services consist of supports to 315 children (age 0 through 21) with DD and intensive supports needs. The majority of these children live at home.

The remainder of individuals received services under this waiver in FY'03. The vast majority of reimbursement is for group home, supported living, work/day, and transportation services to adults with DD. Other services available under this waiver include the following (which are different in scope, duration or amount from any related state plan services): psychological services, personal care, homemaker, respite, occupational therapy, physical therapy, speech therapy, environmental modifications, nutritional evaluations, private duty nursing, meals and respiratory services. The average cost per person served in this waiver was $29,799 in FY03 (excluding the cost of any state plan services accessed by the recipient).

•The "Community Supports" Waiver (0371)----------1915(c):
The Community Supports (CS) waiver was approved by the Centers for Medicare and Medicaid Services in 2001. This waiver served 244 adults (age 18 years and up) with developmental disabilities for the period 7/1/02-6/30/03, expending $1,387,054 in Medicaid funds. The average cost per person was $5,685, thus it is considered a relatively low cost service option. Many persons in the Community Supports waiver live at home, so supports are often purchased to help unpaid primary care givers better meet the needs of an adult family member with DD. Services available in the Community Supports waiver include: homemaker, personal care, respite, residential habilitation, day habilitation, prevocational training, supported employment, environmental modifications, transportation, specialized medical and adaptive equipment, adult companion, private duty nursing, social/leisure/recreation opportunities, health/safety supports and educational services.

Senior Long Term Care (SLTC) Waiver

•Home and Community Based Services – SLTC----------1915(c):

Home and Community Based Services are individually prescribed and arranged according to the individual needs of the consumer. To be eligible for the Home and Community Based Services Program, individuals must be Medicaid eligible, require the level of care of a nursing facility, and be physically disabled or over 65 years of age. To access the program, there must be funds available, or a slot as it is often referred to. The Department contracts with case management teams to develop an individual plan of care in conjunction with the consumer and attending physician. An individual's total HCBS plan of care costs may not exceed a cost limit set by the Department. This program provides case management, respite, adult residential care, specialized services for those with traumatic brain injuries, environmental modifications, adult day health, and personal emergency response systems, just to name a few. This program is vital to allowing consumers to remain in the community instead of entering an institution.

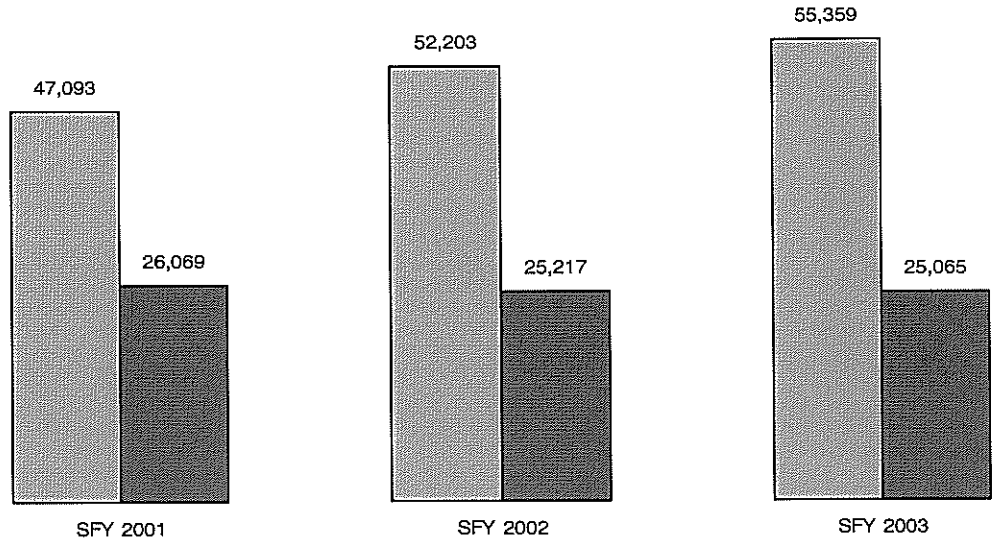
Medicaid Managed Care----------1915 (b) Waiver

PASSPORT To Health (PASSPORT): is Montana's managed health care program. Under PASSPORT, eligible Medicaid enrollees choose a primary care provider (PCP) who manages their health care. Most services must be provided by the PCP or require the PCP's authorization to be reimbursed by Medicaid. The care management provided by the PCP enhances care while reducing costs by minimizing ineffective or inappropriate medical care to Medicaid recipients. PASSPORT saves over $20 million per year in medical costs and improves quality of care.

Quality of and access to care is continuously monitored, and is consistently equal to or better than Medicaid-funded care to similar non-PASSPORT clients.

Medicaid covered 118,000 different people during state fiscal year 2003. The PASSPORT Program covered 82,000 of them, from 55 of 56 counties.

Number of Managed Care Recipients 2001-2003
(as of June 30 each year)



Basic Medicaid Waiver for Able-Bodied Adults----------1115

In 1996 under the authority of an 1115 welfare reform waiver referred to as Families Achieving Independence in Montana (FAIM), Montana implemented a limited Medicaid benefit package of optional services to the same group of adults eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act (the individuals were age 21 to 64, not pregnant and not disabled). The limited Medicaid benefit package was referred to as "Basic Medicaid". The FAIM welfare reform waiver expired on January 31, 2004. A replacement 1115 waiver was approved effective February 1, 2004 continuing basic Medicaid coverage for able-bodied adults ages 21 - 64 who are not disabled or pregnant and who are eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act.

This waiver excludes coverage by Medicaid for certain optional services: audiology and hearing aids, personal assistance services, durable medical equipment, routine eye exams provided by an ophthalmologist or an optometrist, eyeglasses, dental and denturist services. The Department recognizes there may be situations where the excluded services are necessary as in an emergency or medical situation or if essential for employment. Under these defined situations, if the standards and criteria are met, Medicaid may cover the excluded service. Each individual request is evaluated.

Montana Medicaid Covered Services

Services	Categorically Needy– Children	Categorically Needy – Adults	Medically Needy	Family-Related Adults (Basic Medicaid
Ambulance	Yes	Yes	Yes	Yes
Anesthesia	Yes	Yes	Yes	Yes
Audiology	Yes	Yes	Yes	No*
Targeted Case Management	Yes – if in target group	Yes – if in target group	Yes – if in target group	Yes – if in target group
Chemical Dependency	Yes	Yes	Yes	Yes
Chiropractic	Yes	QMB only	QMB only	No
Clinic Services	Yes	Yes	Yes	Yes
Comprehensive Mental Health Services	Yes	Yes	Yes	Yes
Dental Services	Yes	Yes	Yes	No*
Dentures	Yes	Yes	Yes	No*
Prescription Drugs	Yes	Yes	Yes	Yes
Dialysis	Yes	Yes	Yes	No
Durable Medical Equipment	Yes	Yes	Yes	No*
Emergency Rooms	Yes	Yes	Yes	Yes
Eyeglasses/Optician	Yes	Yes	Yes	No*
Family Planning	Yes	Yes	Yes	Yes
Federally Qualified Health	Yes	Yes	Yes	Yes

Services	Categorically Needy– Children	Categorically Needy – Adults	Medically Needy	Family-Related Adults (Basic Medicaid
EPSDT	Yes	No	Children only	No
HCBS Waiver Services	Yes	Yes	Yes	No
Hearing Aids	Yes	Yes	Yes	No*
Home Dialysis Attendant	Yes	Yes	Yes	No
Home Health	Yes;P/A	Yes;P/A	Yes;P/A	Yes;P/A
Hospice	Yes	Yes	Yes	Yes
Inpatient Hospital Care	Yes	Yes	Yes	Yes
Indian Health Service Facility	Yes	Yes	Yes	Yes
Mid-Level Practitioners	Yes	Yes	Yes	Yes
Nursing Facility Services	Yes	Yes	Yes	Yes
Nutrition Therapy	Yes	No; **	Children only; **	No
Occupational Therapy	Yes	Yes	Yes	Yes
Optometric	Yes	Yes	Yes	No*
Organ Transplant	Yes	Limited	Limited for adults	Limited
Out of State Medical Services	Yes; P/A	Yes; P/A	Yes; P/A	Yes; P/A
Outpatient Hospital Care	Yes	Yes	Yes	Yes
Respiratory Services	Yes	No; **	Children only; **	No
Pain management	Yes	Yes	Yes	Yes
Personal Assistance	Yes; P/A	Yes; P/A	Yes; P/A	No
Physical Therapy	Yes	Yes	Yes	Yes
Physician Services	Yes	Yes	Yes	Yes
Podiatry	Yes	Yes	Children only	Yes
Private Duty Nursing	Yes	No; **	No; **	No
Rural Health Clinics	Yes	Yes	Yes	Yes
School Medical Services	Yes	No	Children only	No
Speech therapy	Yes	Yes	Yes	Yes
Transportation	Yes; P/A	Yes; P/A	Yes; P/A	Yes; P/A
X-Ray, Lab and Imaging Services	Yes	Yes	Yes	Yes

* Services may be authorized for certain medical conditions, emergency situations or if essential for employment.

** Home and Community Based Services waiver may include coverage for these services for enrollees.

Medically Needy: See pg.12 for eligibility description.

P/A: Prior Authorization is required.

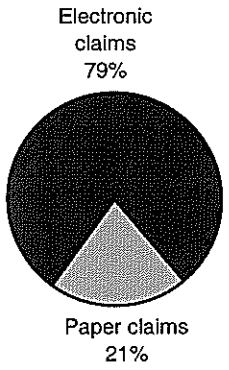
Organ Transplants: Coverage for adults is limited to kidney, cornea, and bone marrow.

PROVIDERS AND CLAIMS PROCESSING

As of October 31, 2004, there are 12,463 providers enrolled as Montana Medicaid providers. During SFY04, 8,938 actively billed Montana Medicaid. Providers must submit claims to Affiliated Computer Services (ACS) 365 days from the dates of service for the claims to be considered filed timely.

ACS is contracted with the Department of Public Health and Human Services to serve as our fiscal agent, below are statistics on the number of claims processed in state fiscal year 2004.

	Number processed	% of Total
Paper claims	1,399,840	21%
Electronic claims	5,267,365	79%
Total claims	6,667,205	100%



From receipt to processing, it takes ACS, on an average, three to six weeks to process paper claims and one to two weeks to process electronic claims.

Last year, ACS received 97,364 calls to their call center; 1,746 new providers enrolled; and 1,550 providers terminated enrollment.

RATE SETTING PROCESS

The Medicaid Program uses several methods to establish payment rates for services:

Fee-for-Service

The Department pays most providers a fee for the service provided. Rates are based on costs or a percentage of charges in accordance with federal regulations. PASSPORT (primary care case management) providers also receive a $3.00 per member per month fee for case management services they provide. In general, provider rates are prospective and payment is final with no settlement back to actual costs.

Reimbursement Systems

Montana Medicaid's reimbursement systems include a Diagnosis Related Groups (DRG) system for inpatient services for some hospitals, Ambulatory Payment Classification (APC) for these same hospitals for outpatient hospital services, cost based reimbursement for hospitals classified as Critical Access Hospitals and Resource Based Relative Value Scale (RBRVS) for physician/professional services. These reimbursement systems use cost, utilization, and other factors – such as measures of relative value or relative acuity – in determining provider payment rates. Medicaid utilizes the same reimbursement systems.

Resource Based Relative Value System (RBRVS)

Montana Medicaid reimburses physicians and other providers who bill on CMS-1500 forms with Medicare's resource based relative value system (RBRVS). Reimbursement is based on the value of a service relative to all other services. The calculations compare the resources needed for a specific service (office expenses, malpractice insurance, and provider work effort and complexity) to those needed for other services. Each service code is assigned one or more relative value units (RVU's) designating its position on the relative value scale. This system was developed nationally by Centers for Medicare & Medicaid Services (CMS), the American Medical Association, and non-physician provider associations; it is adjusted annually. Montana receives the benefit of this large, ongoing investment in research and policy-making without yielding control of costs. The fee for each code is determined by multiplying the RVU by a conversion factor with a dollar value. The conversion factor is Montana-specific to insure the overall budget neutrality of the Medicaid appropriation. The conversion factor is adjusted annually based on the Montana Legislature's most recent biennial appropriation.

RECOMMENDATIONS FROM THE MONTANA PUBLIC HEALTH CARE REDESIGN PROJECT

(Developed in close collaboration with the Public Health Care Advisory Council, significant input from the general public, and work by staff of the Department):

Medicaid Values, Principles and Goals

Background: Given the diversity of groups directly impacted by the Medicaid program—recipients, providers, legislators, bureaucracy, and taxpayers—there are inevitably conflicting goals and priorities among the various groups. The purpose of establishing a common set of fundamental values and guiding principles for the Medicaid program is to provide an agreed on balance among competing goals and a framework within which policymakers can make rational and predictable adjustments to the program. However, by their very nature, fundamental values do not lend themselves to precise definition. Rather, such values serve to focus the decision making process in a way that insures consideration of those issues and concepts deemed essential to the program. In the final analysis, achieving an appropriate balance among individual values is the difficult, imprecise but necessary process that provides the foundation for specific recommendations.

Establishment of a set of common values and principles also provides the foundation for development of specific public policy goals with corresponding objective measures of accountability. The following five core values and associated principles reflect those qualities the Department believes are fundamental to administration of the state's Medicaid program.

Define Fundamental Values, Principles, and Goals

Value: Access

Principle: As part of an overall health-care system, Medicaid should insure access to a set of basic health-care benefits for those Montana citizens most in need and most vulnerable.

Policy Implications:

1. Determine the appropriate level of benefits necessary to meet the health-care needs of the different populations Medicaid serves: adults and children, the blind and disabled, and the elderly;

2. Given limited resources, establish the balance between providing minimally adequate coverage to more people or extensive health-care coverage to a smaller group;

3. Determine the appropriate level of allowable income and resources for Medicaid eligibility and insuring equity in access to services across all programs; and

4. Set adequate provider reimbursement levels to insure recipient access to services without jeopardizing benefits or eligibility.

Value: Personal Responsibility
Principle: Medicaid should facilitate responsibility among recipients for their own health-care decisions.

Policy Implications:
1. Incorporate a set of meaningful incentives and consequences into the Medicaid program to encourage appropriate recipient use of the program;

2. Provide some degree of choice for recipients with regard to provider networks, delivery systems, e.g. fee for service, private insurance, cash and counseling;

3. Establish eligibility criteria in a manner that reasonably insures that those who have the ability to contribute to their own health care expend their own resources prior to using publicly funded health-care programs; and

4. Allow for participation by family members and caregivers in development of treatment protocols.

Value: Accountability
Principle: The Medicaid system must be publicly accountable for quality of care and fiscal integrity.

Policy Implications:
1. Establish appropriate procedures and allocation of adequate resources to monitor quality of care;

2. Develop and maintain information systems that produce the necessary information and data to insure fiscal accountability; and

3. Establish processes and procedures to allow timely and appropriate adjustments to the program to meet unanticipated budgetary shortfalls;

Value: Diversity
Principle: The Medicaid program must be responsive to the needs of different cultures, the geographic availability of resources, and the severity of illnesses.

Policy Implications:
1. Develop programs that are sufficiently flexible to adapt to differences in availability of health-care resources in different regions of the state;

2. Within the overall framework of the Medicaid program, develop programs that address the unique needs of the state's Native American urban and reservation populations; and

3. Develop programs that equitably allocate resources across the diverse populations served by the Medicaid program, e.g. able-bodied adults and children; people with developmental, mental, or physical disabilities; and the elderly.

Value: Public Participation
Principle: Because Medicaid is a publicly funded program, significant decisions regarding changes to the program must incorporate opportunities for broad public input and must respect the opinions of all participants in the process.

Policy Implications:
1. Establish procedures to insure adequate public participation in significant policy decisions effecting the Medicaid program; and

2. Determine an appropriate level of resources necessary to insure public participation and public education regarding the Medicaid program.

Funding Priorities

Background: While the overall purpose of the Medicaid Redesign Project is the containment of expenditure growth to a level that is reasonable and sustainable into the future, the reality is that the Department must be prepared to deal with budgetary shortfalls. Simply stated, cost-cutting options essentially boil down to four alternatives: improve efficiency, pay less, cut services, or restrict eligibility.
Unfortunately, the inherent complexities of Medicaid make easy solutions impossible. Because Medicaid is a fungible system, cutting in one area can actually increase costs in other areas. For example, reducing provider rates can quickly result in restricted access to preventive care and subsequently increased costs for higher-end, long-term care; restrictions in eligibility often simply shift the costs to other public or private sectors of the health-care system with a corresponding loss of substantial federal funding. Thus, while it is easy enough to accurately calculate the savings realized from a specific dollar reduction in travel or the elimination of a specific capital expenditure, estimates of savings are far more slippery when adjustments are made to eligibility, implementing reductions or restrictions on various benefits or when changes are made in reimbursement levels.

With the above caveats in mind, it is imperative that the Department develops a broad strategy for addressing reductions to the Medicaid program that can be communicated to the general public, providers, recipients and the Legislature. However, each budget situation will present a unique set of challenges in terms of the actual dollar amount of reductions required and the current status of various aspects of the program such as existing reimbursement levels, service restriction, etc. Therefore, funding priorities or a cost-cutting strategy must be couched in general terms and serve primarily as a set of guidelines to be applied as circumstances warrant. Given the current status of information available, adjustments made to eligibility criteria are especially difficult to accurately project savings.

Incorporate Funding Priorities

The Department has adopted the following set of funding priorities. These priorities are predicated on the core values adopted by the Department of access, accountability, personal responsibility, diversity, and public participation. However, any decrease in funding will negatively impact some aspect of the Medicaid program. When considering future reductions, the Department's goal should be to attempt a balance of core values while insuring that services for those most in need and most vulnerable are protected. In addition to the core values adopted by the Department, the Department has established a set of guiding principles to set priorities around the relative value of different aspects of the Medicaid program that can be applied when budgetary constraints force decisions regarding reductions in Medicaid expenditures. These principles are as follows:
Client Need: From inception, the Medicaid program has been designed to serve as the final safety net for those individuals who through economic, social, or medical distress have no other recourse to essential medical care.

Principle: When considering changes in policy or reduction in services, the Department and Legislature should first protect those most vulnerable and most in need as defined by the combination of the severity of their economic, social and medical circumstances.

Quality of Care: The Medicaid program must maintain acceptable standards of quality of care.

Principle: When considering changes in policy or reduction in services, preference should be given to eliminating an entire program or service rather than sacrificing the quality of care for several programs or services through dilution of funding.

Quality of Life: The Medicaid program supports and funds the definition of Health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Thus, Medicaid provides services beyond those necessary to protect life or prevent severe injury.

Principle: When considering changes in policy or reduction in services, priority should be given to retaining those services that protect life, alleviate severe pain and prevent significant disability.

The funding strategy employed by the Department will incorporate the above principles in a double-tiered methodology. The first level represents the broad categories of administration, reimbursement, services, and eligibility, with a second subset of categories within each level. The second level categories are simply examples of general areas to be considered and do not necessarily correspond to a fixed menu of hierarchical choices. Any general cost reduction strategy must retain sufficient flexibility to adjust to the specific circumstances of a particular budget situation. Thus, the key word under the present strategy is "considered." The most likely scenario is that reductions will be made that may well include a combination of reductions in Level 1 and Level 2 categories from different areas.

Administration

Level A1:	Non-essential administrative costs, e.g. travel, supplies, capital expenditures, equipment;
Level A2:	Increased vacancy savings, hiring freeze;
Level A3:	Elimination of systems enhancements/essential maintenance;
Level A4:	Staff layoffs.

Reimbursement

Level R1:	Freeze on selected appropriated inflation rate increases;
Level R2:	Increased recipient cost sharing;
Level R3:	Selective rate reductions;
Level R4:	Across-the-board rate reductions.

Services

Level S1:	Minor service restrictions for selected populations;
Level S2:	Major service restrictions for optional populations;
Level S3:	Elimination of selected optional services;
Level S4:	Elimination of optional services.

Eligibility

Level E1:	Reduced outreach efforts;
Level E2:	Tighter asset criteria;
Level E3:	Adjustments to income eligibility criteria;
Level E4:	Elimination of selected optional eligibility categories.

Management Principles

Background: In 2003, Medicaid became the largest system of health-care services in the nation, serving more people and expending more public funds than Medicare. In Montana during fiscal year 2003, over 45 percent of childbirths were paid for through Medicaid and over 108,000 individuals were eligible for Medicaid benefits, including 65,000 children, 18,000 seriously disabled people, and 9,000 elderly people. State expenditures for Medicaid are expected to reach $650 million in fiscal year 2004 and to exceed $680 million by fiscal year 2005. Given the number and vulnerability of people who are dependent on Medicaid for their essential health-care needs and the very significant amount of public funding involved, it is essential that decisions regarding changes in benefits, eligibility, or allocation of resources are based on timely and accurate information.

Although fiscal accountability is an extremely important component of the overall management of the Medicaid program, of equal importance is a sound understanding of the characteristics of populations served, appropriateness of benefits provided, and the efficiency of service delivery systems. Too often decisions made strictly on the basis of financial considerations and anecdotal information result in significant unintended consequences that ultimately outweigh any fiscal savings. For example, a seemingly minor 2 percent across-the-board reduction in reimbursement rates may have relatively little impact on access to hospital-based services but a profound impact on access to

personal care attendants and a devastating impact on the developmental disabilities service network.

Previously, the Department has not had the capacity or inclination to adequately evaluate the crucial role eligibility determination plays as a primary gatekeeper for Medicaid services. Historically, the eligibility process has been more closely aligned with the general welfare functions of the Department (e.g. TANF, food stamps, etc.) than coordinated with policies directly effecting Medicaid. An important part of the redesign process has been a thorough examination of all the various ways individuals become eligible for Medicaid services (there are currently over 30 different paths to Medicaid eligibility) and establishment of procedures that insure consideration of eligibility as a key component during any future considerations of changes to the program.
A particular area of concern for the Department is the adequacy and accuracy of data and management issues related to Medicaid services provided to Native Americans. Each federally recognized tribe has a somewhat different governing structure and process for providing Medicaid services. Some rely exclusively on IHS, some are covered under Public Law 93-638 and provide part of the health-care services directly with other services provided by IHS, and some tribes have a compact with the federal government and receive a direct appropriation from Congress.

There are a number of advantages to the current administrative structure of Montana's Medicaid program. The fact that the four administrative divisions focus on selected populations within the Medicaid program (such as children, pregnant women, the mentally ill, the elderly, or the developmentally disabled), rather than including all populations under a single administrative unit, makes it possible to more clearly target resources and services to meet the special needs of the different populations. At the same time, there are legitimate differences in priorities that can create confusion and frustration among both recipients and providers if the Department does not have a common set of management principles and policies that, when applied, result in uniform and predictable interactions.

Implement Management Principles and Data Analysis

To meet the challenges associated with timely management of a program as complex and important as Medicaid, the Department has established the following set of explicit principles and expectations for each division responsible for Medicaid services and those staff charged with administering the Medicaid program. The Director of the Department will periodically review the overall status of the Medicaid program and compliance with established principles and procedures.

The management principles include the following components:

a. Overall supervision, coordination and accountability for all aspects of the Medicaid program are vested in a single individual, the state's Medicaid director;

b. To assist the Medicaid director and division staffs, a special unit called the Office of Planning, Coordination, and Analysis has been established to coordinate, establish common formats, collect and analyze Medicaid data. This unit will also have

sufficient resources to provide technical assistance to staff at the program level regarding use of data and common budgeting format;

c. The Department's existing major computer systems for tracking eligibility and service utilization (TEAMS and MMIS) will be revised to coordinate information databases to allow tracking service utilization information by population groups, enhance eligibility determination including demographic and resource information, and an improved Decision Support System that will allow program managers easy and timely access to expenditure data;

d. Each program manager will be directly involved in the initial development of his/her program's budget and will be provided a clear understanding of the assumptions and process used to derive the Department's final annual budget for the entire Medicaid program;

e. After legislative approval of the Department's annual Medicaid appropriation, each program manager will be provided a detailed copy of the appropriations supporting the program he/she is responsible for managing;

f. Throughout the fiscal year, program managers will provide periodic budget status reports of expenditures and utilization trends within their programs. On a timely basis, these budget status reports will be compiled and reviewed by the Medicaid director in collaboration with other information and analysis conducted by the Division of Operations and Technology and budget staff assigned to the Director's Office. This information is shared with the Governor's Budget Office on a routine basis;

g. With appropriate input from program managers, division administrators will be responsible for early identification of potential fiscal pitfalls and the policy adjustments that might be necessary to contain expenditures within authorized appropriations;

h. Because changes to services, eligibility, or reimbursement levels within one aspect of the Medicaid program can have serious ramifications for other aspects of the program, prior to implementation of any significant adjustments within a single program, information will be shared across all programs to avoid unintended conflicts;

i. Every proposed change in the Medicaid policy will include an assessment of the potential human and fiscal impact of the change as well as a method of evaluating the actual impact of the change if implemented;

j. The Department will develop a 10-year historical record of Medicaid program expenditures and utilization data by services including a description of program/policy changes, when they were implemented, the reason why they were implemented and an assessment of their impact; and

k. The Medicaid director will insure that division administrators and program managers have access to the resources necessary to effectively manage their programs: specifically, training and user friendly access to appropriate data systems. Given adequate resources, division administrators and program managers will be individually accountable for the quality and fiscal integrity of their respective programs.

In order to deal specifically with data and management issues effecting the tribes and IHS, the Department will work with tribes to foster a spirit of cooperation and identify current institutional barriers limiting the participation of tribal members in the Medicaid program and develop strategies, including education, to improve the mechanics of providing Medicaid services to Native Americans by:

a. Insuring that tribes have an adequate opportunity to review and verify data used to monitor Medicaid services and eligibility status, as well as data used to modify or promote changes in Medicaid policy;

b. Consulting with tribal representatives on the effective use and appropriate sources of information on Native American health-care needs; and

c. Conducting technical assistance workshops, at the request of tribal representatives, to address issues specific to tribal needs regarding such matters as centralized billing procedures, sound health-care business practices, and development of needed health-care infrastructure.

In addition, the Department will insure compliance with requirements of HB 608 by consulting directly with the tribes on any policy changes that may impact services or programs operated by the tribes.

Reimbursement Principles

Background: Establishing appropriate levels of Medicaid reimbursement or provider rate increases is not a simple matter. Montana's Medicaid program includes over 12,000 service providers operating under a variety of different reimbursement mechanisms. For a number of reasons, Montana's Medicaid program does not have a rational system for adjusting provider reimbursement rates that can be equitably applied across all the various provider groups. As a consequence, provider rate increases have historically been implemented primarily on an individual program basis in response to specific crises or political pressure. Given the status of Montana's economy into the foreseeable future, it is critically important that the state develop the data and processes necessary for policymakers to make informed decisions regarding adjustments to reimbursement levels in a manner that is objective, publicly verifiable, and equitable to all provider groups.

The amount and manner of reimbursement Medicaid pays providers for the services they deliver has a significant impact on a number of important aspects of Montana's health-care system. Inadequate reimbursement levels can impact the overall quality of care delivered, the degree to which Medicaid recipients have access to health-care providers

and services, the number and type of services provided, the ability of service providers to attract and retain qualified staff, the amount paid for services by other purchasers of health care, and the overall financial stability of the state's health-care system. On the other hand, if Medicaid pays too much for selected services, inappropriate changes in service utilization patterns may occur in order to maximize provider revenue, issues of equity and fairness between providers of different types of services are exacerbated, and scarce resources become unavailable for other services and programs.

As noted, Medicaid does not operate under a single reimbursement system. Over the years, an extremely complex series of different reimbursement systems have evolved in an effort to meet the needs of various provider groups. For example, Medicaid reimburses for physician and professional services using a modification of the federal Medicare payment system (RBRVS) based on the relative value of the service provided. Inpatient hospital charges are based on another federal payment system (DRGs) that sets a flat payment according to specific diagnosis and average length of hospital stay, regardless of the actual hospital cost. Nursing homes are reimbursed according to a complex formula that sets an overall average rate per day adjusted for acuity level of residents and a lump sum payment of Inter Governmental Transfer (IGT) funds depending on whether the facility is privately operated or county owned.

Other entirely different systems are used for calculating reimbursement for out-of-state hospitals, Community Mental Health Centers, Federally Qualified Health Centers, state-administered institutional care, Durable Medical Equipment, and the level of reimbursement (premium) paid for the Children's Health Insurance Plan (CHIP) or any future insurance premium assistance program the Department might propose.

Another important factor that must be taken into consideration is the relative importance of Medicaid reimbursement against the total revenue received by a given provider. If providers are dependent upon Medicaid as their primary source of revenue, then even minor adjustments to the reimbursement level will have a significant impact on their ability and willingness to provide services. For those providers for whom Medicaid accounts for a lesser portion of their overall revenue, other strategies, e.g. less administrative overhead, might prove to be a more effective incentive for increasing access. Even minor adjustments to developmental disability, personal assistance, or nursing home provider rates can have a far more profound impact on access to services than comparable adjustments to rates paid to other professionals or even hospitals.

A prerequisite to establishing a fair and objective reimbursement system is a common base of objective data for each of the various reimbursement mechanisms. Once the data are acquired, procedures need be established to insure any policy decisions regarding adjustments to reimbursement rates are based on objective criteria and equitably applied to all providers.

The Department should develop the data and process necessary for policymakers to make informed decisions regarding adjustments to reimbursement levels in a manner

that is objective, publicly verifiable, and equitable to all provider groups. Such data systems and process would include the following:

1. In order to establish a common database of information for all Medicaid service providers and populations served by the Medicaid program, and to provide accurate, consistent and timely budget information, each Medicaid program should conduct the following activities:

a. Gather, analyze and compare all data currently available regarding the actual and reasonable cost of providing Medicaid services;

b. Require providers of any service category or type for which Medicaid is the primary payer to submit audited data on the actual cost of providing that service;

c. Conduct a cost-of-care analysis, including children's mental health services and other services highly dependent on Medicaid reimbursement;

d. Gather, analyze and compare the rates paid by other purchasers of the same or similar services to those paid by Medicaid;

e. Establish an objective definition of reasonable access to care;

f. Gather and analyze data and information related to the access to care such as the number of Medicaid providers of the services, trends in utilization of the services and any other pertinent information available to the Department;

g. Where possible, assess the impact of changes in reimbursement on the utilization of services and quality of care; and

h. Gather and analyze data on the percentage of total service provider revenue that is derived from Medicaid for each Medicaid service.

2. In addition and where applicable, the Department should conduct an analysis of the following options as alternatives to specific dollar increases in reimbursement rates.

a. Providing tax incentives for providers who deliver services to Medicaid recipients;

b. Paying a higher reimbursement rate to providers who serve a high number of Medicaid recipients;

c. Making pretax payments into the deferred compensation accounts of individual providers;

d. Simplifying and expediting the Medicaid billing and payment systems and requirements; and

e. Streamlining and simplifying administrative requirements and regulations where possible while continuing to protect the health, safety and welfare of Medicaid recipients.

3. When adjusting Medicaid reimbursement rates, the Department should evaluate all requests against a common set of criteria to insure a rational and objective process is used that is equitably applied to all provider groups. The relative status of each provider group should be measured against the following set of criteria:

a. The actual, reasonable costs of providing each service at the level of quality required by law and/or regulation;

b. The reimbursement rates paid by other public and private purchasers of the same services;

c. The impact of the reimbursement rates on Medicaid recipients' access to medically necessary care;

d. The degree to which the reimbursement rates encourage the use of the most appropriate medically necessary services;

e. The impact of the reimbursement rates on the quality of care delivered to recipients;

f. The degree to which the providers of care are dependant on Medicaid revenue for this service; and

g. The level of funding, and any specific directions, provided by the Legislature.

The Department should also work with tribes and the IHS to engage CMS and Congress to support efforts to have all services for Medicaid-eligible Native Americans included in the State Medicaid Plan be eligible for 100 percent FMAP regardless of the location where services are provided.

EXPENDITURE ANALYSIS

Medicaid services are funded by a combination of federal and state (and in some situations, local funds). The federal match rate for Medicaid services is based on a formula that takes into account the state average per capita income compared to the national average.

The matching rate for Medicaid administration is set at either 50%, 75% or 90% depending on the type of administrative activities and pre-approval from Centers for Medicare & Medicaid Services (CMS).

Most administrative cost fall into the 50% matching rate, however program activities that are related to medical claims processing, MMIS and certain others can be matched at an enhanced rate of either 75% or 90%. Services provided for family planning also receive an enhanced match rate of 90%.

A decrease in the federal matching rate has a negative effect on the total dollars available for funding services.

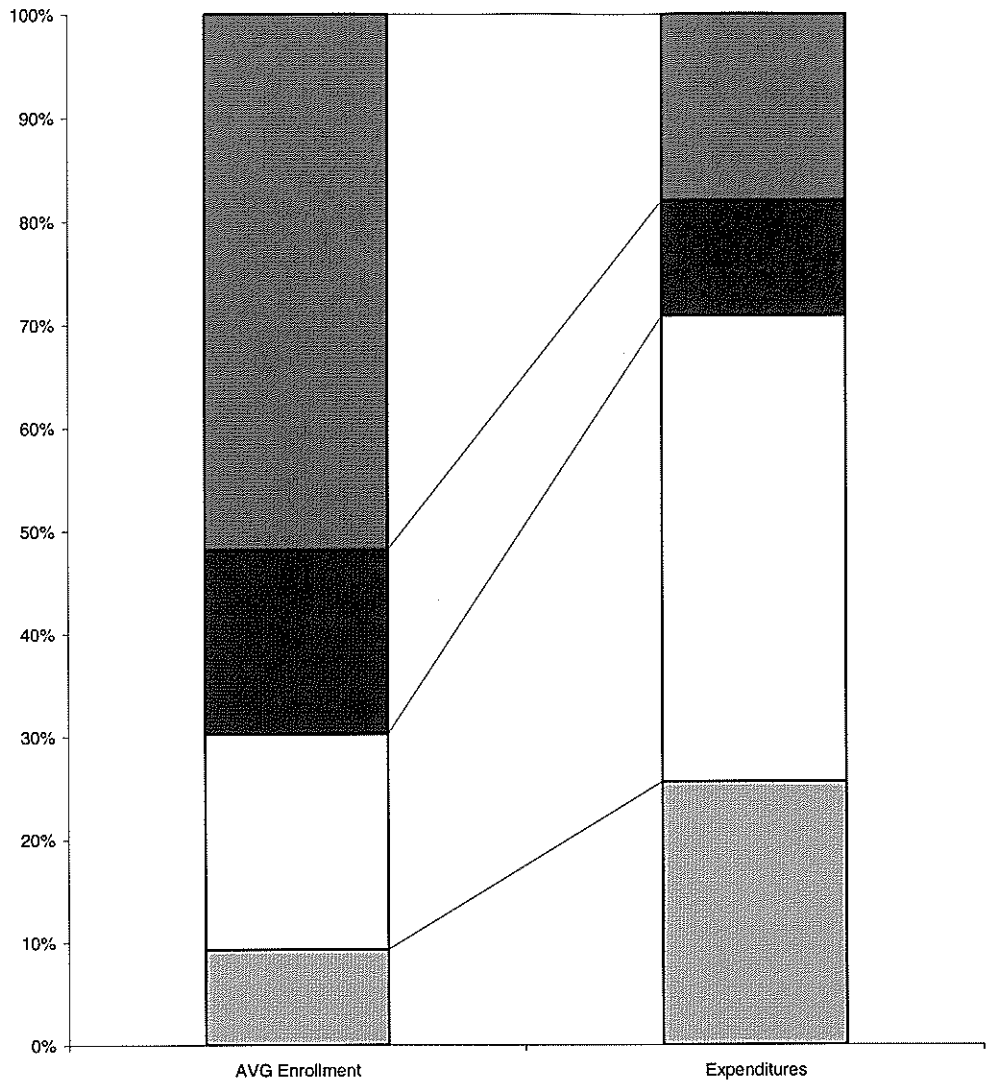
Montana Medicaid Benefits Federal Matching

State Fiscal Year	2000	2001	2002	2003*
Federal Match Rate	72.30%	73.04%	72.83%	74.15%
State Funds Percentage	27.70%	26.96%	27.17%	25.85%

- Effective April 1, 2003 until June 30, 2004 the Federal matching rate was enhanced by 2.95%.

State Fiscal Year	2004	2005	2006	2007
Federal Match Rate	75.36%	71.96%	70.71%	70.08%
State Funds Percentage	24.64%	28.04%	29.29%	29.92%

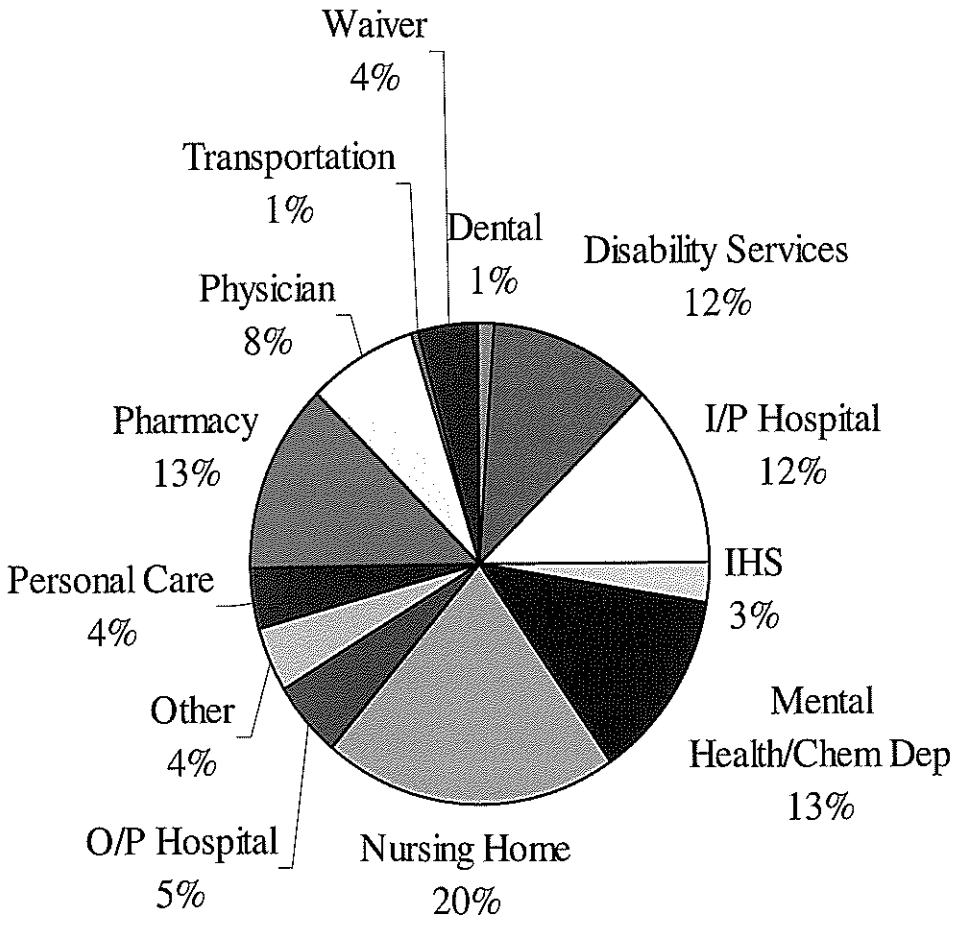
SFY 2003 EXPENDITURES by Major Aid Category



	AVG Enrollment	% of Enrollment	Expenditures	% of Expenditures
Aged	7,736	9%	$ 145,817,084	26%
Blind and Disabled	17,380	21%	$ 257,224,638	45%
Adults	14,890	18%	$ 63,425,014	11%
Children	43,014	52%	$ 102,574,541	18%

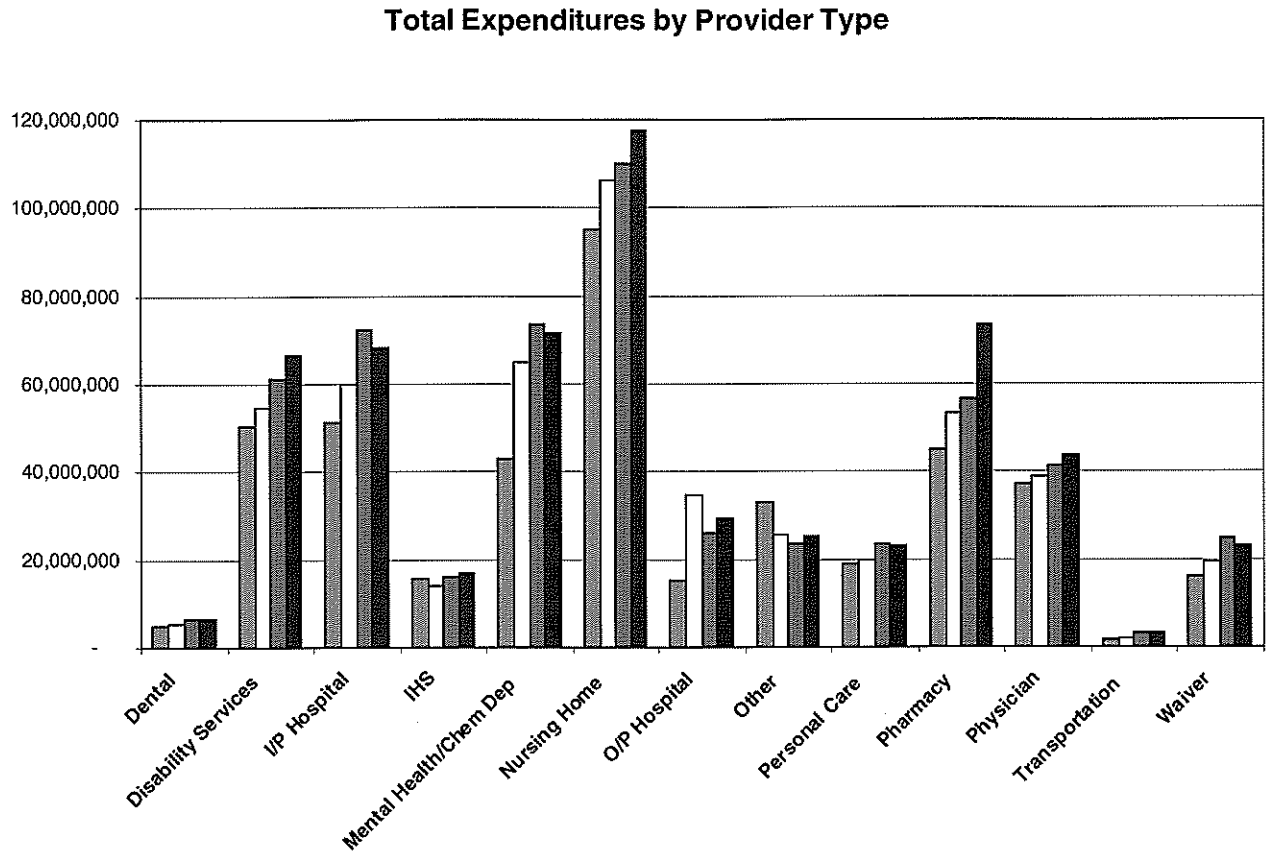
The chart at the left shows Medicaid enrollment in 2003 by aid category. The chart to the right reflects funds expended by aid category. The aged and disabled are a relatively small percentage of the entire Medicaid population, but account for a high percentage of the Medicaid funds expended. Conversely, children represent almost half of the Medicaid population but account for less than one-fifth of the cost.

SFY 2003 EXPENDITURES by Provider Type



Please see the following page for actual expenditures.

SFY 2000 to 2003 EXPENDITURES by Provider Type

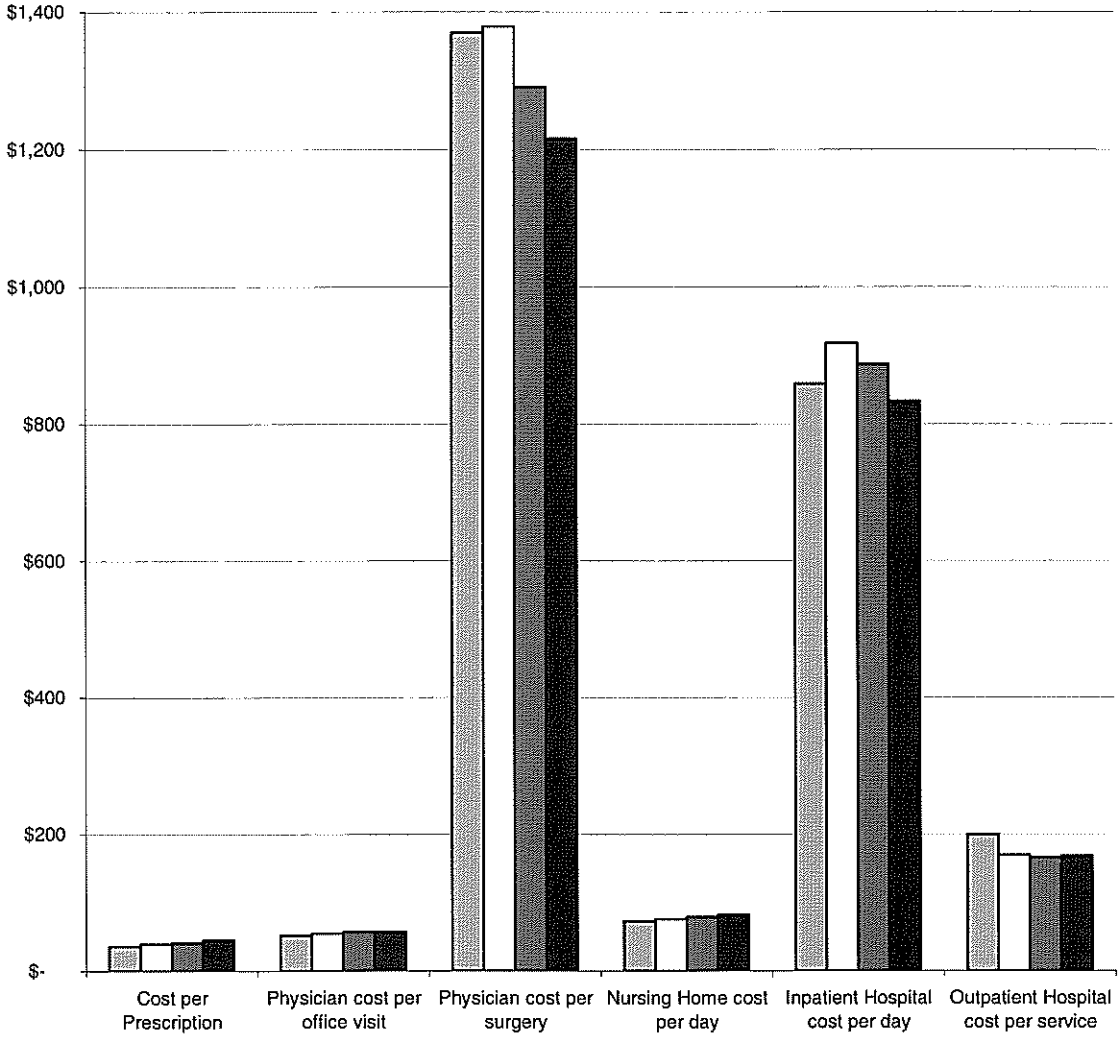


	SFY 2000	SFY 2001	SFY 2002	SFY 2003
	SFY 2000	SFY 2001	SFY 2002	SFY 2003
Dental	5,031,558	5,284,304	6,807,666	6,657,316
Disability Services	50,528,005	54,650,290	61,284,846	66,420,214
I/P Hospital	51,106,262	60,025,484	72,332,358	68,423,606
IHS	15,635,018	14,227,751	16,000,841	16,949,592
Mental Health/Chem Dep	43,070,255	64,876,883	73,617,290	71,431,106
Nursing Home	95,168,886	106,275,623	110,001,784	117,387,029
O/P Hospital	15,169,197	34,738,378	25,982,987	29,347,636
Other	33,289,739	25,487,294	23,526,817	25,223,479
Personal Care	18,995,408	19,976,273	23,431,095	23,123,157
Pharmacy	45,132,058	53,433,399	56,604,791	73,580,949
Physician	37,415,589	38,761,251	41,307,481	44,039,024
Transportation	1,792,075	2,265,359	3,389,077	3,142,788
Waiver	16,161,572	19,566,880	24,751,756	23,315,381
	428,495,622	499,569,168	539,038,789	569,041,277

Pharmacy expenditures have been reduced by the amount of rebated collected.

Cost Per Service

Regardless of the provider type, the cost of service is an average of the various services rendered by the provider. Each year the average cost per service is strongly affected by a number of factors including patient acuity, new procedures, supply cost, new technology, and inflation.

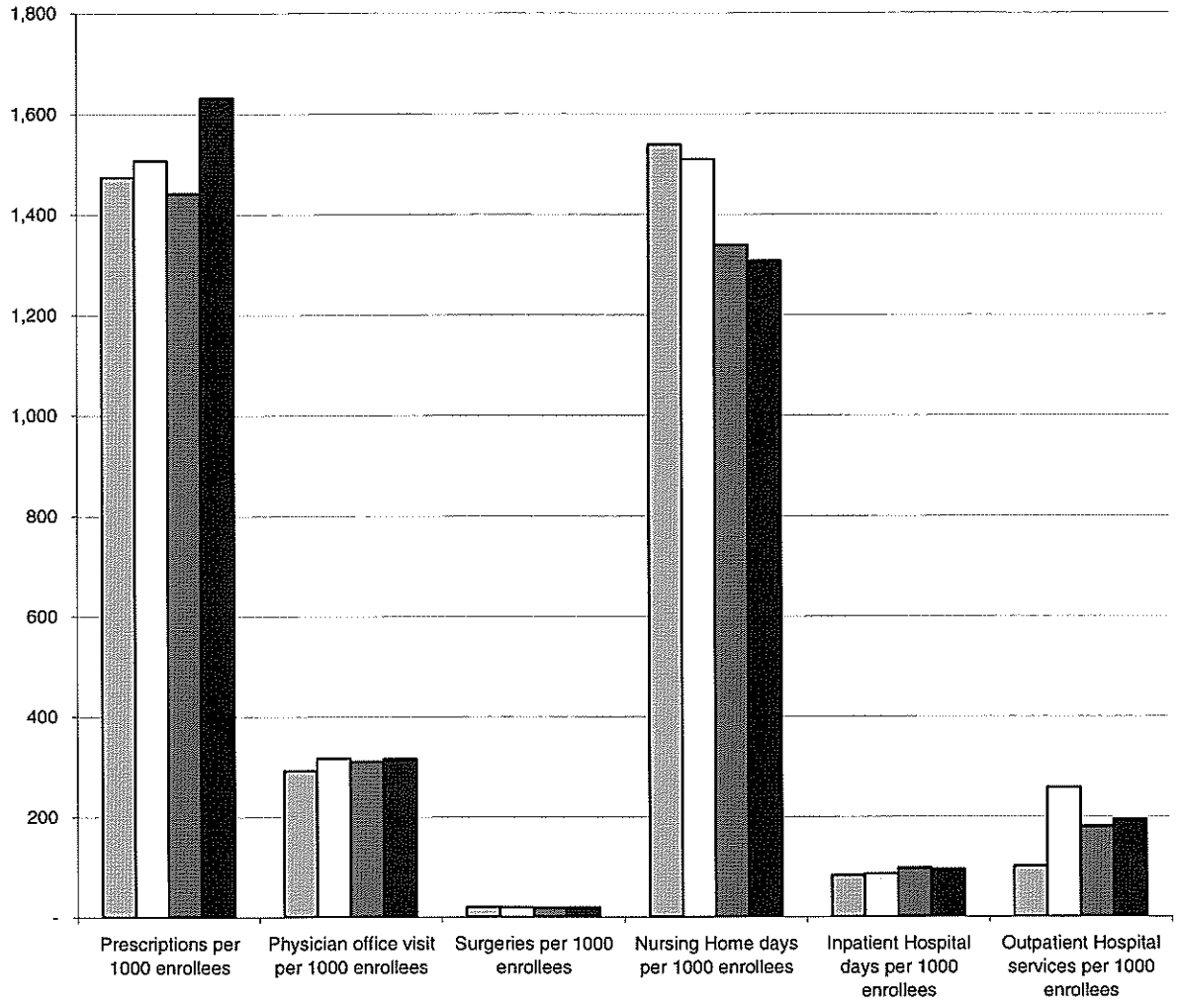


	2000	2001	2002	2003
Cost per Prescription	$ 36	$ 40	$ 41	$ 45
Physician cost per office visit	$ 52	$ 55	$ 57	$ 57
Physician cost per surgery	$ 1,370	$ 1,379	$ 1,290	$ 1,216
Nursing Home cost per day	$ 73	$ 76	$ 79	$ 83
Inpatient Hospital cost per day	$ 859	$ 918	$ 887	$ 833
Outpatient Hospital cost per service	$ 199	$ 169	$ 166	$ 168

Physician and Hospital services exclude services where Medicare is the primary payor.
Prescription expenditures have been reduced by rebates collected.

Units of Service

The definition of a unit of service varies greatly both within and between provider types. Medicaid covers approximately 10,000 procedures. These procedures can vary from extreme complexity to procedures as simple as administering a bandage to a minor wound. The total units of service is affected each year by a number of factors including patient acuity, technology changes, and changes in treatment protocol.

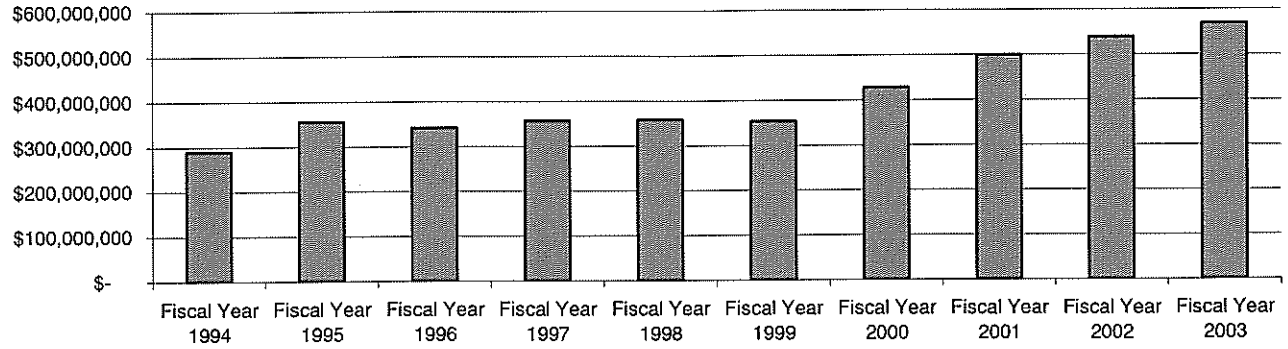


	2000	2001	2002	2003
Prescriptions per 1000 enrollees	1,474	1,507	1,442	1,632
Physician office visit per 1000 enrollees	292	317	310	315
Surgeries per 1000 enrollees	20	19	18	19
Nursing Home days per 1000 enrollees	1,538	1,509	1,340	1,308
Inpatient Hospital days per 1000 enrollees	83	86	97	95
Outpatient Hospital services per 1000 enrollees	101	258	180	194

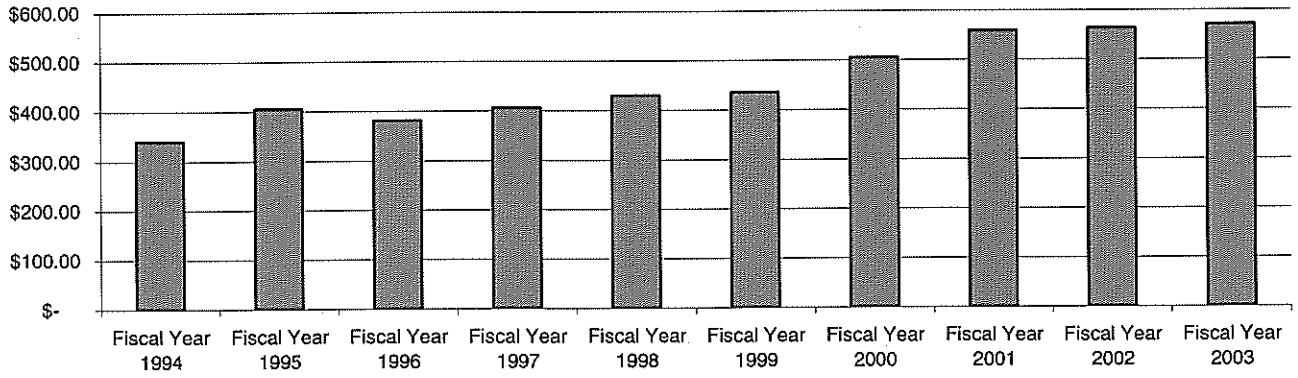
Physician and Hospital services exclude services where Medicare is the primary payor.

10 Year History of Expenditures and Enrollment

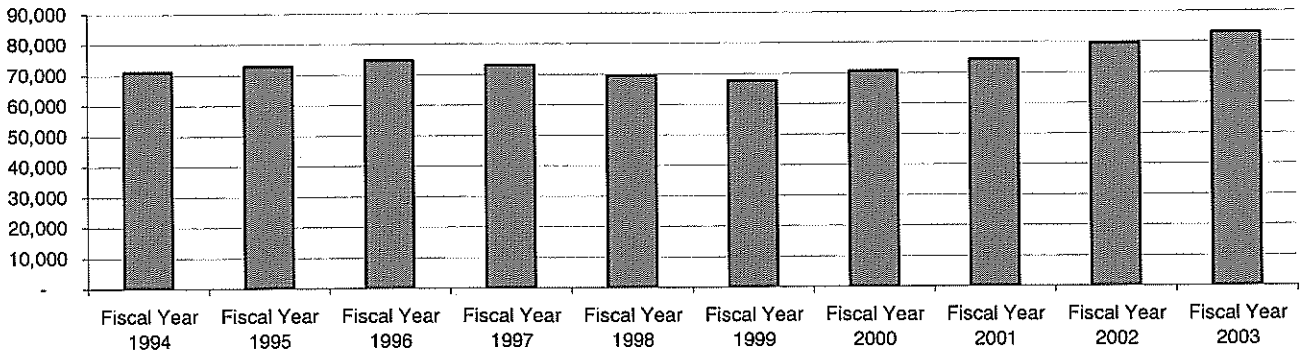
Total Annual Expenditures



Expenditures/enrollee/month

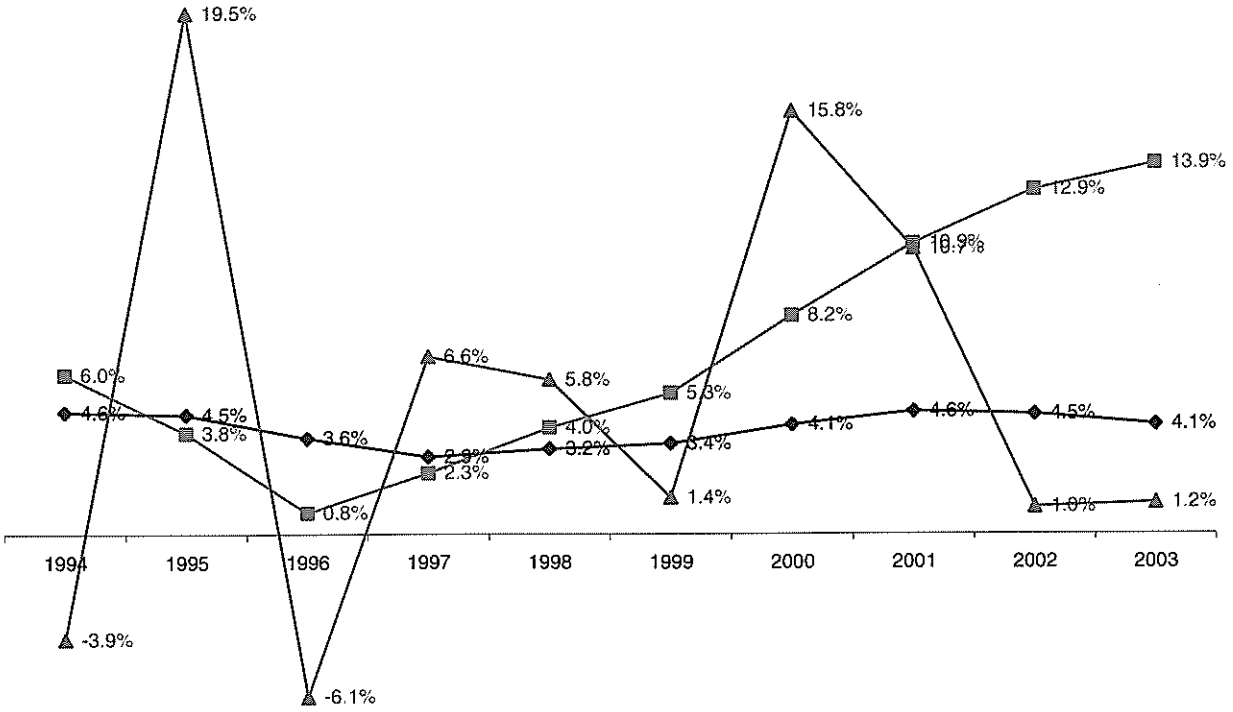


Average Monthly Enrollment



This chart excludes the cost of CHIP, State Fund Mental Health, and Indian Health Services.

Medicaid growth compared to the Health Care Price Index (HCPI) and the Consumer Price Index (CPI) from 1994 to present

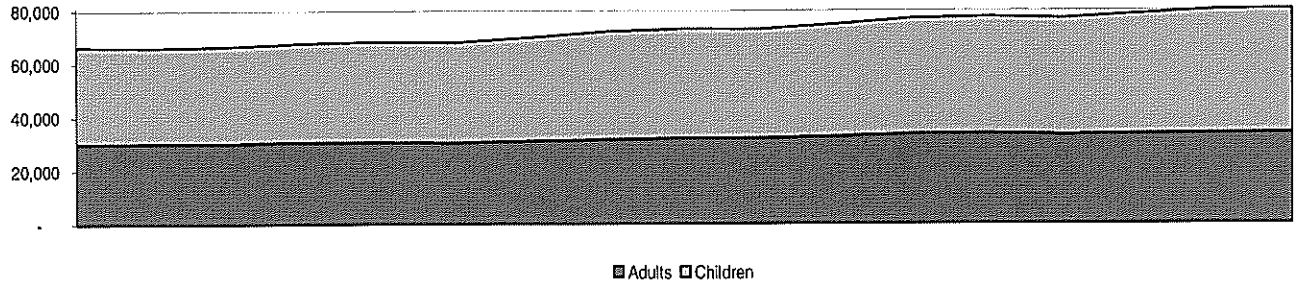


	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Health Care CPI	4.6%	4.5%	3.6%	2.9%	3.2%	3.4%	4.1%	4.6%	4.5%	4.1%
Health Insurance Premium	6.0%	3.8%	0.8%	2.3%	4.0%	5.3%	8.2%	10.9%	12.9%	13.9%
Montana Medicaid	-3.9%	19.5%	-6.1%	6.6%	5.8%	1.4%	15.8%	10.7%	1.0%	1.2%

HCCPI from US Department of Labor 1982-1984 base year.

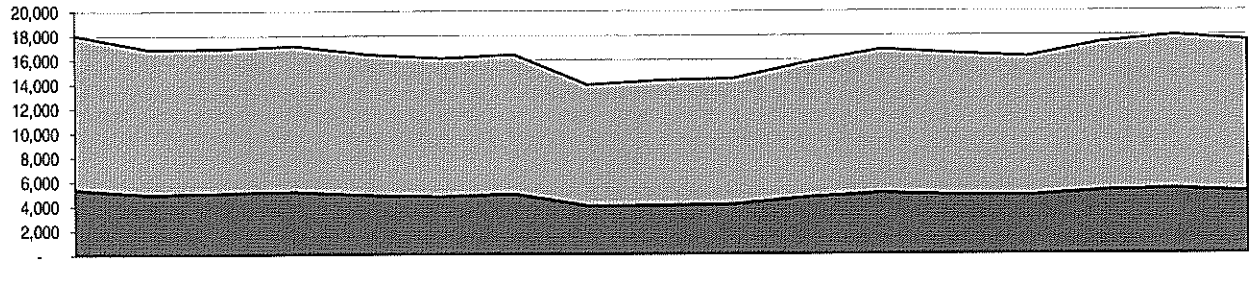
Medicaid Increase is based on the per enrollee per month cost increases

All Medicaid Eligibles, 1999 - 2003



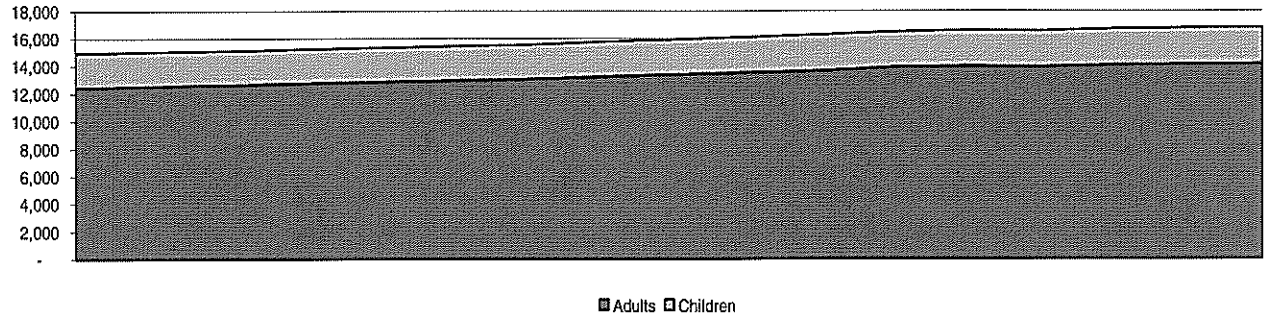
	Jun-99	Sep-99	Dec-99	Mar-00	Jun-00	Sep-00	Dec-00	Mar-01	Jun-01	Sep-01	Dec-01	Mar-02	Jun-02	Sep-02	Dec-02	Mar-03	Jun-03
Total	66,449	66,253	66,758	67,936	68,372	67,993	69,970	72,109	73,162	73,058	74,728	76,994	77,420	76,990	78,670	80,179	80,424
Adults	30,145	30,260	30,454	30,775	30,708	30,565	31,085	31,765	32,159	32,150	32,792	33,598	33,752	33,427	33,709	33,931	33,837
Children	36,304	35,993	36,304	37,161	37,664	37,428	38,885	40,344	41,003	40,908	41,936	43,396	43,668	43,563	44,961	46,248	46,587

TANF/Medicaid Eligibles, 1999-2003



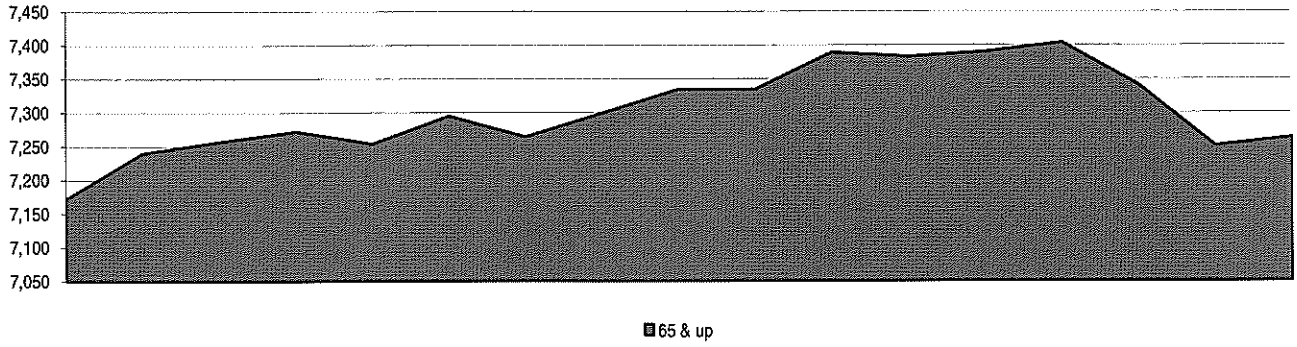
	Jun-99	Sep-99	Dec-99	Mar-00	Jun-00	Sep-00	Dec-00	Mar-01	Jun-01	Sep-01	Dec-01	Mar-02	Jun-02	Sep-02	Dec-02	Mar-03	Jun-03
Total	18,054	16,907	16,932	17,152	16,447	16,112	16,401	13,958	14,300	14,474	15,773	16,829	16,473	16,237	17,382	17,945	17,526
Adults	5,365	4,983	5,079	5,195	4,913	4,785	4,953	4,003	4,064	4,149	4,711	5,049	4,865	4,814	5,215	5,380	5,131
Children	12,689	11,924	11,853	11,957	11,534	11,327	11,448	9,955	10,236	10,325	11,062	11,780	11,608	11,423	12,167	12,565	12,395

Disabled/Medicaid Eligibles, 1999-2003



	Jun-99	Sep-99	Dec-99	Mar-00	Jun-00	Sep-00	Dec-00	Mar-01	Jun-01	Sep-01	Dec-01	Mar-02	Jun-02	Sep-02	Dec-02	Mar-03	Jun-03
Total	14,972	15,062	15,114	15,237	15,353	15,441	15,543	15,750	15,950	16,106	16,270	16,482	16,558	16,545	16,711	16,759	16,798
Adults	12,452	12,559	12,655	12,771	12,867	12,949	13,048	13,232	13,408	13,538	13,659	13,898	13,975	13,960	14,085	14,121	14,169
Children	2,520	2,503	2,459	2,466	2,486	2,492	2,495	2,518	2,542	2,568	2,611	2,584	2,583	2,585	2,626	2,638	2,629

Aged/Medicaid eligibles, 1999-2003



	Jun-99	Sep-99	Dec-99	Mar-00	Jun-00	Sep-00	Dec-00	Mar-01	Jun-01	Sep-01	Dec-01	Mar-02	Jun-02	Sep-02	Dec-02	Mar-03	Jun-03
65 & up	7,172	7,240	7,257	7,272	7,254	7,295	7,264	7,299	7,335	7,335	7,389	7,383	7,390	7,404	7,341	7,251	7,263

COST CONTAINMENT

The Medicaid Program continues to develop cost containment measures that would enhance the cost effectiveness and efficiency of the program. Some examples include:

School Based Services:

- The Office of Public Instruction certifies the match for the general fund portion for Medicaid reimbursed health-related services written into the Children's Individualized Education Plans (IEPs).

Nurse First:

- Nurse Advice Line – Toll Free and Confidential Nurse Line that triages caller's symptoms and guides callers to seek care at the appropriate level of care.
- Disease Management – Eligible Medicaid clients diagnosed with asthma, diabetes, and chronic heart failure receive individualized counseling and education that empowers them to be more active in their health care. Results are decreased exacerbations and Medicaid expenditures, and improved patient quality of life.
- Team Care – Utilization control through education and restriction. Clients with a history of using Medicaid services at an amount or frequency that is not medically necessary are mandated in the program. TC clients are managed by a Team consisting of a PASSPORT primary care provider, one pharmacy, the Nurse First Advice Line, and DPHHS.
- Patient Registry – Clinical value metrics and utilization patterns for PASSPORT clients are forwarded to providers; these reports are a tool aimed to assist providers managing clients.

PASSPORT Primary Care Case Management Program:

- PASSPORT was implemented in 1993, with most Medicaid clients required to participate. In PASSPORT, clients must choose one primary care provider who then performs or provides referrals for almost all of the client's care. PASSPORT saves over $20 million per year in medical costs and improves quality of care. Periodic surveys show that over 80% of both providers and clients are satisfied with PASSPORT.

Out-of-State Inpatient & Outpatient Hospital:

- Prior authorization: a mandatory advance approval for all inpatient hospital services out-of-state. Encourage the utilization of available health resources in-state.

Senior and Long Term Care:

- Effective July 1, 2003 and 2004 Nursing Facility provider taxes were increased to provide additional funding for Nursing Facilities during the 2005 biennium.

- Beginning in July of 2000 instituted a standardized prior authorization for personal assistance services process, which stabilized growth and reduced expenditures.

- Beginning in January of 2001 this program utilized additional funds in the form of an intergovernmental fund transfer for counties to provide additional payments to at risk nursing facilities.

- Effective July 1, 2001 a new price based reimbursement methodology was adopted for reimbursement of nursing facilities in the state.

Contracts to provide services:

- In SFY 2003 entered into a contract with Mountain Pacific Quality Health Foundation to assist with transportation services.

- In SFY 2003 entered into a contract with Walman Optical to provide eyeglass services (effective December 1, 2002).

Pharmacy:

- Prior Authorization: A mandatory advance approval of the drug before it is dispensed for any medically accepted indication.

- Drug Utilization Review: Prospective & Retrospective review of drug use.

- Over-the-counter drug coverage: When prescribed by a physician a cost effective alternative to higher priced federal legend drugs.

- Mandatory generic substitution: Requires pharmacies to dispense the generic form of the drug.

- Other permissible restrictions – minimum or maximum quantities per prescription or number of refills.

- Preferred Drug List and supplemental rebates: Preferred Medicaid's Drug utilization Review Board/Formulary committee selects drugs in various classes of medications. Extensive review of the medications by the Board yields drugs that represent the best value to the Medicaid program. Many of the preferred drugs also provide supplemental rebates above what is currently offered to the Medicaid program.

Drug Rebate Collection:

The Department has 1.5 FTEs dedicated to the rebate program and the use of Drug Rebate Analysis and Management System (DRAMS). The staff conducts claim audits and invoice audits prior to invoicing pharmaceutical manufacturers. These duties assure more accurate invoices to the manufacturers and eliminate or reduce disputes with the manufacturers. This assures more timely payments from the manufacturers. Drug rebates continue to average approximately 20% of the Medicaid pharmacy expenditures.

CHRONOLOGY OF MAJOR EVENTS IN MONTANA MEDICAID

2004 – Nurse First Care Management program was implemented to reduce ineffective use of medical services. Key components are a Nurse Advice Line for most individuals on Medicaid and a Disease Management program for those with chronic conditions such as asthma, diabetes and congestive heart failure.

2004 – FAIM Basic Medicaid waiver expired on January 31, 2004. A replacement 1115 waiver was approved effective February 1, 2004 continuing basic Medicaid coverage for able-bodied adults ages 21 - 64 who are not disabled or pregnant and who are eligible for Medicaid under - Sections 1925 or 1931 of the Social Security Act.

2004 - Hospital tax was implemented. This change provided increased reimbursement to hospitals using a state tax on hospitals matched with federal Medicaid dollars.

2004 – Nursing facility provider tax increased from $2.80 to $4.50 to fund nursing facility provider rates.

2003 – Eliminated coverage of gastric bypass surgery and routine circumcisions at the recommendation of the Medicaid Coverage Review Panel composed of Montana physicians.

2003 – Child and Family Services Division began billing Medicaid for targeted case management services provided to children at risk of abuse and neglect.

2003 – Outpatient reimbursement methodology was changed to Ambulatory Payment Classification (APC).

2003 – On January 10, 2003 implemented a 7% net pay reduction to providers (sunset June 30, 2003).

2003 – On February 1, 2003 reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system (sunset June 30, 2003).

2003 – On August 1, 2003, reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system. Changed all interim reimbursement rates for cost-based facilities to the hospital specific cost to charge ratio.

2002 – Increase Cost Sharing requirements for which the Medicaid eligible persons are responsible.

2002 – Began covering outpatient chemical dependency for adults.

2002 – Implemented a 2.6% net pay reduction to providers (sunset June 30, 2002).

2002 – Implemented reimbursement reductions to hospital inpatient services by reducing the base rates, decreasing the DRG weights by 2%, and eliminating the additional catastrophic case payment.

2002 – July 1, 2001 moved to a case mix price-based system of reimbursement for nursing facility providers.

2001 – Implemented a mandatory generic substitutive policy for pharmaceuticals in the outpatient drug program.

2001 - The Montana Legislature passed legislation creating the Montana Breast and Cervical Cancer Treatment program for low income uninsured women with breast or cervical cancer diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment.

2001 – Implemented new reimbursement methodology for Ambulance & Dental Services. Included an 18% increase in funding for the dental program.

2000 – Medicaid HMO program was discontinued due to low penetration and high administrative expenses.

2000 – Nursing Facility Intergovernmental Transfers are implemented to save state general fund.

2000 – Hospital Intergovernmental Transfers are implemented.

2000 – Prior Authorization was required in Personal Assistance Services.

1999 – Mental Health Managed Care abandoned per legislative requirement.

1999 - Ambulatory Surgical Center provider reimbursement was restructured to align with Medicare reimbursement methodologies.

1998 – Area Agencies on Aging converted state general fund to buy slots to expand Waiver.

1997 - New MMIS contract was instituted with Consultec as the fiscal agent (Consultec later changed it's name to Affiliated Computer Services – ACS).

1997 – Resource Based Relative Value System (RBRVS) was implemented to reimburse Physicians, Mid-Level Practitioners and Therapies.

1997 - Mental Health Managed Care was implemented. This program institutes a full-risk, capitated managed care contract for all mental health services statewide.

1997 – Prior authorization was required of Home Health Agency services.

1996 – Federal welfare reform was passed on August 22, 2996. Under the Personal Responsibility and Work Opportunities Reconciliation Act, Medicaid was "de-linked" from AFDC/TANF and began operating without regard to eligibility for cash assistance.

1996 - Departmental reorganization was implemented. Reorganization results in a decentralization of Medicaid; services are managed in divisions primarily responsible for services to specific populations. For example, the Addictive and Mental Disorders Division manages all Medicaid mental health services.

1996 - New outpatient prospective payment system was introduced. The system uses Day Procedure Groups (DPGs) to bundle services at one basic rate.

1995 - Liens and Estates Recovery Program was implemented by the legislature.

1995 - The Families Achieving Independence in Montana (FAIM), welfare reform waiver, received federal approval. The FAIM program began phasing-in implementation in February 1996. Even though the cash assistance caseload experienced a significant reduction, Medicaid eligibility continued for most of families. Cost savings were due to the reduced package of services under FAIM Basic Medicaid, not because of decreased caseloads.

1995 - The Medicaid HMO program was implemented for AFDC recipients in counties where HMOs exist.

1993 - Passport to Health program was implemented. The program assigns a primary care case manager provider to each participating Medicaid enrollee as a health care manager and gatekeeper of services. The program has yielded significant savings in subsequent years and maintained quality of care.

1993 - New hospital reimbursement system was implemented. The system features updated DRG rates and restrictions on procedures outside of the basic reimbursement package. This change results in significant savings in subsequent years.

1993 - Out of state hospital initiative was implemented. This program restricts the use of higher cost out of state hospitals when in state hospitals provide the same services. This initiative results in significant savings in subsequent years.

1993 - Medicaid coverage for inpatient psychiatric services was terminated by the legislature

1992 - Federal OBRA 89 increased eligibility for pregnant women and children under age 6 to 133% of the federal poverty level. OBRA 89 stipulates that children are eligible for all medically necessary services.
1992 - Federal OBRA 90 was implemented. A major component of this mandate is to increase eligibility for children aged 6 through 18 to 100% of the federal poverty level. This mandate is being phased in through 2002.

1992 - "Residential Psychiatric Services" was implemented as a Medicaid Service. This service brings rapid increases in cost for the next several years.

1992 - Drug Rebate Program was implemented and began to return a significant portion of prescription drug costs to the state in the form of rebates.

1992 - Formulary and Drug Utilization Review Program was implemented for Medicaid pharmacy services. This program provides significant internal controls and cost savings in subsequent years.

1991 - Nursing home provider tax was implemented. This change increased reimbursement to nursing homes using a state tax on nursing homes matched with federal Medicaid dollars.

1990 - Federal OBRA 87 was implemented. This federal mandate imposed new regulations for nurse aides, client safety, and client screening. This mandate affects primarily the nursing home industry and increased Medicaid costs through increased reimbursement to providers. OBRA87 also raised the threshold for financial eligibility to 100% of poverty for pregnant women and children younger than 6 years.

1988 - "Inpatient Psychiatric Services for Children under age 21" became a Medicaid service. This service increased costs rapidly for the next several years.

1987 - New Hospital reimbursement system was instituted. This Diagnosis Related Group (DRG) system is a prospective rate system.

1985 - New MMIS was instituted with Consultec as the fiscal agent.

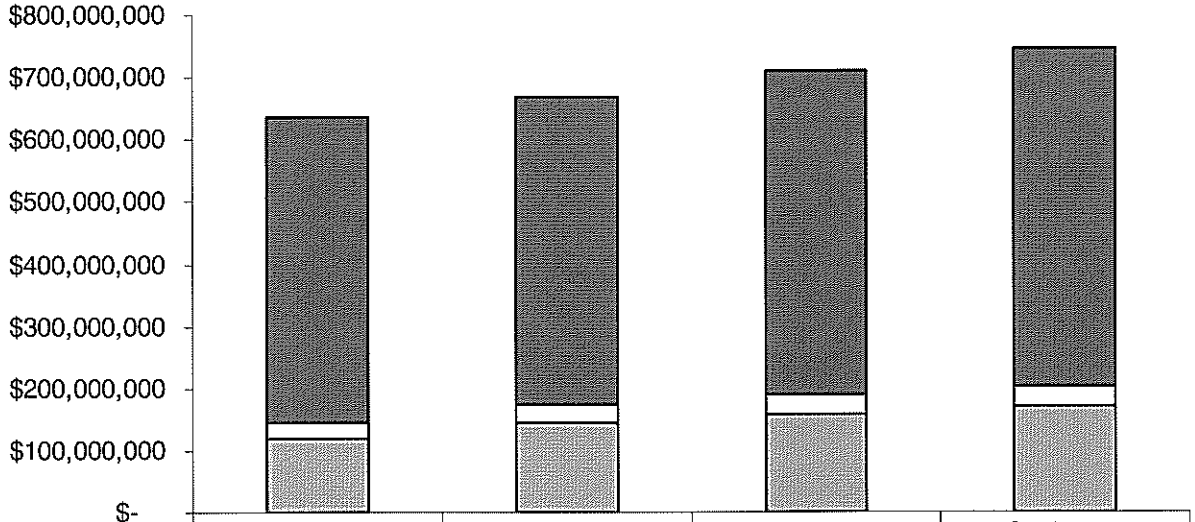
1983 - Department lost Boren Amendment lawsuit to Montana Health Care Association (Nursing Homes) for insufficient reimbursement rates. Financial implications include: 1) retroactive payments for prior years; 2) increased reimbursement rates for subsequent years.

1983 - The HCBS waiver was implemented. This program consists of multiple services not traditionally offered to Medicaid recipients and designed to help people stay in their own homes rather than moving to an institution.

1982 - Prospective reimbursement system was instituted for the Nursing Home program.

EXPENDITURE AND ENROLLMENT PROJECTIONS

Projected State Funds Expenditures in Millions:



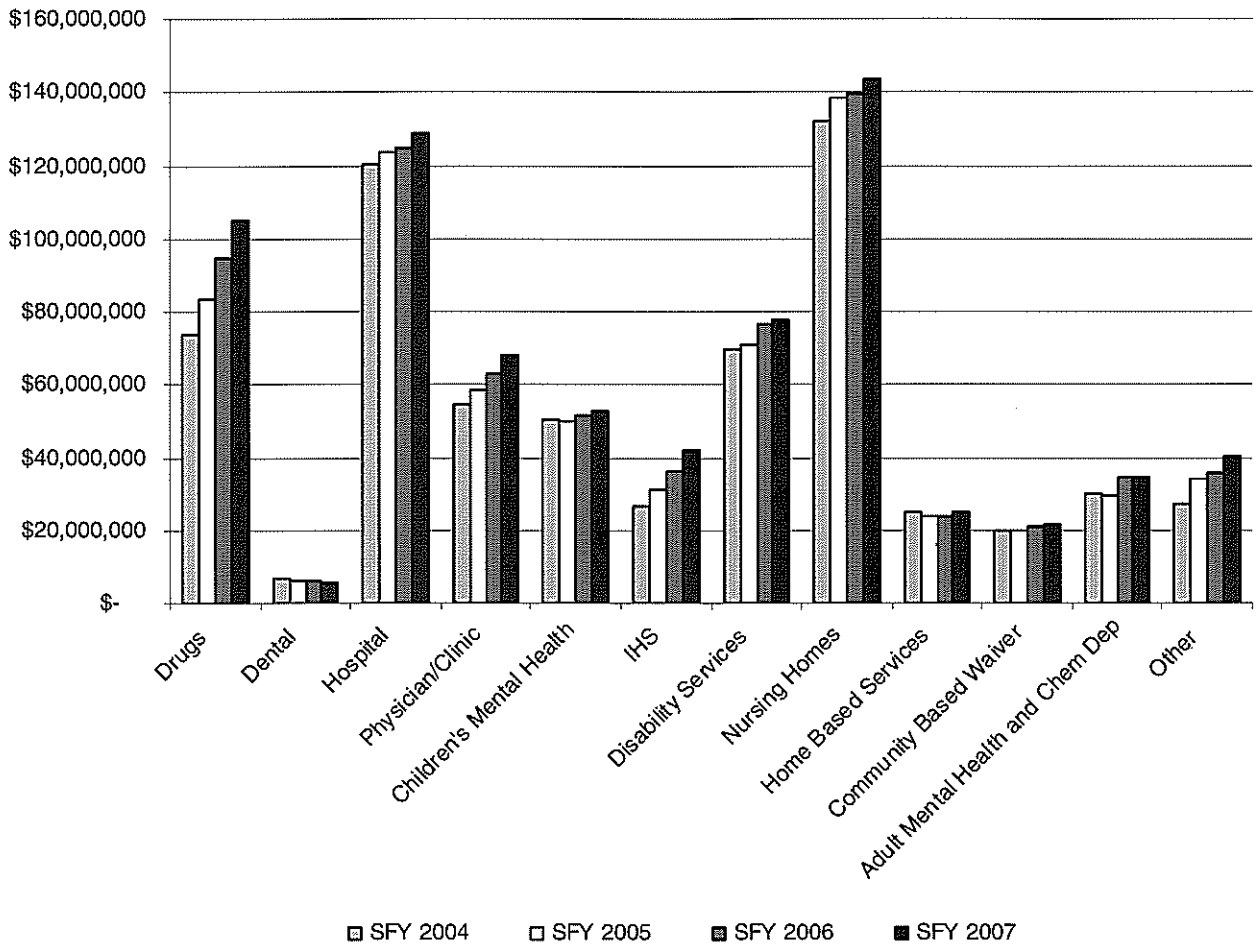
	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Federal Funding	$493,137,410	$497,217,720	$520,376,712	$544,247,803
State Special Revenue	$23,470,688	$27,995,867	$30,467,963	$32,619,991
State General Fund	$119,903,467	$144,657,447	$157,676,126	$168,786,074

Excludes Medicare buy-in. Fiscal year 2004 is based on projections as of July 2004.

State Funds Percentages of Medicaid

State Fiscal Year	2004	2005	2006	2007
Federal Match Rate	75.36%	71.96%	70.71%	70.08%
State Funds Percentage	24.64%	28.04%	29.29%	29.92%

Projection Expenditures by Provider Type



Excludes Medicare buy-in. Fiscal year 2004 is based on projections as of July 2004. Prescription expenditures have been reduced by rebates.

GLOSSARY OF ACRONYMS

ACS: Affiliated Computer Services (previously Consultec)

AFDC: Aid to Families with Dependent Children

AMDD: Addictive and Mental Disorders Division

APC: Ambulatory Payment Classification

CAHRD: Child and Adult Health Resources Division (now Health Resources Division)

CD: Chemical Dependency

CFSD: Child and Family Services Division

CHIP: Children's Health Insurance Plan

CMS: Centers for Medicare and Medicaid Services (replaced HCFA)

CPI: Consumer Price Index

DD: Developmental Disabilities

DPGs: Day Procedure Groups

DRAMS: Drug Rebate Analysis and Management System

DRG: Diagnosis Related Group

DSD: Disability Services Division

EFE: Essential For Employment

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment

FAIM: Families Achieving Independence in Montana

FFS: Fee-for-Service

FMAP: Federal Medical Assistance Percentage (the Federal reimbursement percentage for approved medical services)

FPL: Federal Poverty Level

FQHC: Federal Qualified Health Center

FY: Fiscal Year (state FY is July 1—June 30; federal FY is Oct 1—Sept 30)

HCFA: Health Care Financing Administration (now Centers for Medicare and Medicaid Services – CMS)

HCBS: Home and Community Based Services

HCPI: Health Care Price Index

HCSD: Human and Community Services Division

HMO: Health Maintenance Organization

HRD: Health Resources Division

ICF/MR: Intermediate Care Facility for Mental Retardation

IHS: Indian Health Services

IMD: Intermediate Care Facility for Mental Disease

MCDC: Montana Chemical Dependency Center

MDC: Montana Developmental Center (ICF/MR)

MH: Mental Health

MHO: Mental Health Organization

MMHNCC: Montana Mental Health Nursing Care Center

MMIS: Medicaid Management Information System

MSH: Montana State Hospital (IMD)

NDC: National Drug Code

NH: Nursing Home

OBRA: Omnibus Budget Reconciliation Act

PAS: Personal Assistance Services

PD: Physically Disabled

QAD: Quality Assurance Division

RBRVS: Resource-Based Relative Value Scale

RHC: Rural Health Clinic

RVU: Relative Value Unit

SAMHSA: Substance Abuse and Mental Health Services Administration

SDMI: Severe and Disabling Mental Illness

SED: Serious Emotional Disturbance (children and adolescents)

SFY: State Fiscal Year (July1—June 30)

SLTC: Senior and Long Term Care Division

SSI: Supplemental Security Income

TANF: Temporary Assistance for Needy Families